101st Congress
2d Session

COMMITTEE PRINT

S. PRINT
101-100

The HealthCareCrisis

A Report to the American People

by
Senator Edward M. Kennedy
Chairman
Committee on Labor and Human Resources

Prepared by the
Committee on Labor and Human Resources
United States Senate

June 1990

Printed for the use of the
Committee on Labor and Human Resources

S542-3

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON: 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

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CONTENTS

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	Page
INTRODUCTION	1
FINDINGS	3
I. The Uninsured and Underinsured	3
II. Long-Term Care	8
III. Rising Cost of Health Care	10
IV. Failing Financial Condition of Health Institutions	11
V. Drugs and AIDS	12
VI. Conclusions and Recommendations	14
THE CRISIS IN NEW YORK CITY: THE TWIN EPIDEMICS OF AIDS AND DRUGS ADD TO THE STRAINS ON AN OVERBURDENED SYSTEM	
Background:	
AIDS In New York City	17
The South Bronx	18
The Bronx-Lebanon Hospital Site Visit	20
Outpatient AIDS Clinic	20
Inpatient AIDS Unit	21
New York City Hearing: AIDS, Drugs, and the Urban Health Care Crisis	23
Panel 1: People Living With AIDS	23
Panel 2: Professionals On The Front Line	25
Panel 3: The Local/Federal Partnership	28
Mobile Medical Van and Meeting With Religious Leaders	29
LOS ANGELES: THE HEALTH CARE CRISIS ON THE WEST COAST	
Background:	
Health Care In Los Angeles	31
Child Health	32
Site Visit to the Pediatric Failure-To-Thrive Clinic at Harbor-UCLA Medical Center	35
Site Visit to the Emergency Room at Harbor-UCLA Medical Center	36
Los Angeles Hearing: The Uninsured, Long-Term Care, and the Collapse of the Los Angeles County Trauma System	37
Panel 1: Citizens	38
Panel 2: Professionals On The Front Line	41
THE CRISIS IN ST. LOUIS: THE VIEW FROM MIDDLE AMERICA	
Background:	
Missouri Health Care System	45
Uninsured And Underinsured Population	45
Hospitals And Primary Care	47
Primary Care	47
Employers	47
Malpractice Costs	48
Overview	48
People's Health Center, Maplewood	48
St. Louis Hearing: Working People Face The Health Care Crisis	50
Panel 1: Citizens	50
Panel 2: Professionals On The Front Line	53
Ford/UAW Meeting, Hazelwood	55

SPARTA, GEORGIA: THE HEALTH CARE CRISIS IN RURAL AMERICA

	Page
Background:	
Rural Health	57
Hospitals	58
Health Care Personnel	59
Sparta, GA	60
Home Visit	60
Site Visit: Hancock Memorial Hospital	61
Site Visit: Hancock County Primary Health Care Center	62
Sparta Hearing: The Health Care Crisis In Rural America	64
Panel 1: Citizens	64
Panel 2: Professionals On The Front Line	68
"Open Microphone Session"	70
Overview	71
APPENDIX A	
I. The Basic Health Benefits for All Americans Act (S. 768/H.R. 1845)	73
Private Job-Based Insurance for Workers	73
Public Insurance for Others	73
Cost of Plan	73
Small Business Insurance	74
Cost Containment Features	74
APPENDIX B	
II. "Lifecare"—The Long-Term Care Insurance Act of 1988	75
Home Care Program	75
Nursing Home Care	75
Additional Provisions	75
Financing	76
APPENDIX C	
Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (S. 2240)	76
Title I—Emergency Assistance	76
Title II—Comprehensive Care Programs	77
Title III—HIV Health Services Research	78
Attachment A—Disaster Relief Areas	78
Attachment B—States Block Grants—Title II	78

INTRODUCTION

America faces a health care crisis of unprecedented dimensions. Too many Americans are uninsured and underinsured, and the number is growing every year. Too many of the elderly and their families cannot afford essential long-term care. Health care costs are too high and are rising rapidly out of control. Too many health care institutions are facing collapse.

Each of these aspects of the crisis is exacerbated by the twin epidemics of AIDS and drugs, which are also major health care problems in their own right.

One of the most disturbing features of the crisis is its impact on America's children, who deserve a healthy start in life, but are too often failing to receive it, with serious implications for the country's future.

To explore the scope of the health care crisis and evaluate possible legislative remedies, the Senate Committee on Labor and Human Resources visited 4 communities across the country: New York City, Los Angeles, St. Louis, and rural Sparta, GA. Each site visit included a committee hearing and visits to key health care facilities and other institutions affected by the health care crisis.

As these visits made clear, the Nation's health care crisis is continuing to worsen, and more effective remedies are needed to address the numerous dimensions of the challenge. In each community, there was growing public awareness of the seriousness of the problem and broad public support for more effective action.

A comprehensive solution to the national health care crisis can and must be enacted. Four major recommendations form a framework for such a solution:

First, businesses should be required either to provide private, job-based insurance meeting minimum standards to their employees and their employees' families or to make contributions to a public program providing coverage. Most workers already have access to health insurance on the job; all businesses should be required to provide or contribute to it.

Second, a public insurance program should be established by expanding Medicaid to include those who cannot get health insurance through employment. Premiums should be based on ability to pay. No Americans should be denied the fundamental right to health care because they are unemployed.

Third, the elderly and the disabled deserve the same security against the cost of long-term care that Social Security provides against poverty in retirement, and Medicare provides against the cost of doctor and hospital care. Long-term care is the un-

finished business of Social Security and Medicare, and it is time for Congress to complete the job.

Fourth, these measures must be coupled with tough new steps to bring health care costs under control.

In addition to these comprehensive reforms, more targeted programs directed at the AIDS and drug epidemics are vital. For AIDS, the key ingredients are (1) an effective research program to develop a cure for the disease; (2) carefully conceived and implemented prevention programs to reduce the spread of the disease; and (3) specific steps to reduce the burden of the disease on individuals and institutions.

For drugs, we need an increased national commitment to the war on drugs and a reordering of our priorities. Law enforcement, interdiction, treatment and prevention are all essential, but prevention and treatment continue to be short-changed in the current national strategy.

The committee has already recommended certain measures to meet these needs. On July 12, 1989, the committee approved the Basic Health Benefits for All Americans Act. This legislation would assure adequate, affordable insurance for every American. Either this legislation or equivalent proposals being developed by the Pepper Commission and a bipartisan working group of Senators from the Labor and Human Resources and Finance Committees should be brought to the Senate floor for action this year. A program of universal health insurance coverage is the most important single step that can be taken to provide all Americans with the health care they need, to give America's children the healthy start in life they deserve, and to provide health care institutions with the financial stability they require in order to maintain essential services.

The evidence gathered by the committee in these field visits makes a compelling case for the need for prompt, bold, and comprehensive action by Congress. My family has been fortunate in being able to obtain the best in health care. Wherever the committee went, it was clear that too many Americans are denied the access to the quality health care that should be the birthright of every citizen.

I am deeply indebted to the citizens and the health policy experts in each community who shared their insights and experience with the committee, and with me. Through their efforts, we are closer to the day when quality health care will be a basic right for all, not just an expensive privilege for the few.

EDWARD M. KENNEDY, *Chairman,*
Committee on Labor and Human Resources
June 1990

FINDINGS

In December, 1989, the Senate Committee on Labor and Human Resources conducted hearings and field investigations in New York City, Los Angeles, St. Louis, and Sparta, GA. The committee found overwhelming evidence of a crisis in the health care system that threatens the well-being of every American family in every community. While each community had unique problems, the central dimensions of the crisis were the same.

The health care challenge the Nation faces is more serious than at any time since the enactment of Medicare in 1965. No one is immune—young or old, rich or poor, city or farm.

The crisis involves 4 central elements:

The large and growing number of uninsured and underinsured Americans;

The lack of affordable long-term care insurance for senior citizens and the disabled;

The excessive burden of health care costs on businesses and workers; and

The failing financial condition of large numbers of hospitals and other institutions that provide essential health services to millions of Americans.

In addition, the health care crisis is exacerbated by the problems of drug abuse and AIDS. These two epidemics present serious health issues in their own right, but they also exacerbate each of the 4 elements noted above.

A particularly disturbing aspect of the 4-part crisis is its impact on children, who deserve a healthy start in life, but too often fail to receive it. Unless prompt action is taken to address these problems, the future of our Nation's children is a cloudy one, with serious implications for America's future.

I. The Uninsured and Underinsured

The growing number of the uninsured is unacceptable. In 1979, 29 million Americans were uninsured. Today, the number is 37 million, and it is increasing every year. Sixty million Americans have health insurance that the Department of Health and Human Services found to be inadequate. Altogether, there are almost 1 hundred million Americans who do not have adequate health insurance protection—more than one-third of the Nation. Half of all Americans contacted by collection agencies every year are in debt because they have medical bills they cannot pay. Even those who are adequately insured today may be at risk tomorrow—if their

employer drops coverage, or if the family breadwinner changes jobs or loses a job.

Reprinted with permission of American Nurses' Association © 1985 (photo by Terry Selby)

Patient receiving treatment at Long Island shelter for the homeless in Boston.

Two-thirds of the uninsured are workers or dependents of workers. They cannot get health insurance at an affordable price, because their employers do not offer it. One-third of the uninsured are unemployed. They deserve a helping hand from Government, so that no American is denied the fundamental right to health care.

Lack of adequate insurance can be devastating to families, both in financial terms and in terms of timely access to needed health care:

Each year, according to the Department of Health and Human services, 2.4 million American families experience catastrophic health care costs in excess of $3,000 that insurance does not cover.

According to surveys by the Robert Wood Johnson Foundation, 1 million Americans seek health care annually but are turned away because they cannot pay. Another 14 million do not even look for care they need, because they know they cannot afford it.

Two-thirds of the uninsured with serious health symptoms (such as spontaneous bleeding, loss of consciousness, unexplained weight loss) do not see a doctor for these symptoms.

The uninsured make 40 percent fewer physician visits than the insured; they are hospitalized 19 percent less often, even though their average health is poorer.

A study in Washington, DC, found that 40 percent of hospital admissions of uninsured patients (excluding obstetrics and trauma cases) could have been avoided if primary care had been available.

The impact on children of the growing number of uninsured is particularly troubling:

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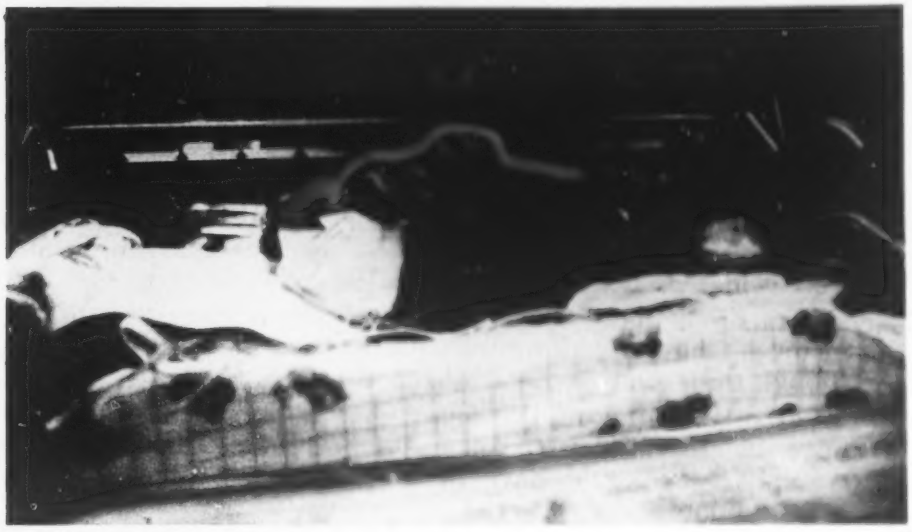
Pediatric patient in Westchester County Medical Center (NY).

One in every 5 children in America today—12 million children in all—have no health insurance coverage.

Thirty-five percent of poor children—more than 4 million children below the poverty line—have no coverage because of gaps in Medicaid.



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Premature infant at high risk of medical complications.

Two out of 3 pregnant women who are uninsured do not get the low cost, effective prenatal care their infants need. Because of this neglect, too many infants do not even survive the first year of life. America ranks a shameful 19th among developed countries in infant mortality rates—with higher proportions of children dying in the first year of life than in Japan, Sweden, Finland, Switzerland, Canada, the Netherlands, France, Denmark, West Germany, Norway, East Germany, Spain, Australia, the United Kingdom, Belgium, Italy, Austria, and New Zealand.

Forty percent of children do not receive the basic childhood vaccinations that are the first line of defense against serious diseases.

A quarter of all children do not see a physician even once during the course of a year. Often, for those who do, the only family doctor they know is the hospital emergency room.

The lack of adequate health insurance is a uniquely American problem. Every other industrialized country except South Africa has taken steps to provide health insurance coverage for all its citizens. It is not a problem faced only by poor or unemployed Americans. Citizens from all walks of life are vulnerable:

As noted, two-thirds of the uninsured—23 million—are workers or dependents of workers.

Eleven million of the uninsured live in poverty, but an even larger number—15 million—have incomes more than twice the poverty level.

Forty-eight percent of the working uninsured are employed by small businesses with fewer than 26 employees (30 percent of the total work force is employed by such businesses).

Twenty-three percent of the working uninsured are employed by businesses with more than 1,000 employees (38 percent of the total work force is employed by such businesses).

Three million, six hundred thousand disabled citizens are uninsured.

Seven million Americans are insured but would be considered medically uninsurable by insurance companies if they were to seek a new policy for any reason.

In each community visited by the committee, examples of the human tragedies associated with lack of health insurance abounded. Health care providers and experts told us the problem was worsening.

Three witnesses heard by the committee typify the problems faced by hard-working citizens.

Jim Krause of San Dimas, California is a 61-year-old small businessman, successfully operating a family print shop for many years. Jim knew the importance of health insurance and paid $300 a month for a family policy. Despite always paying his premiums, Jim lost his coverage when his insurer declared bankruptcy. Jim looked for another policy but had trouble finding a company willing to cover him because of an emergency room visit for a minor health problem. While he was looking for coverage, he suffered a minor stroke which resulted in a hospital bill of $3,300. His doctor recommended additional tests, but Jim felt that he could not afford them. Had those tests been conducted, Jim might have avoided the massive heart attack that struck him 1 year later.

The Krause family now has $42,000 in debts, and has lost its entire savings. Jim has had to declare bankruptcy. His wife works full-time, but since her employer offers no health insurance, the family is still unprotected. Jim's health is improving, but he still has significant medical costs each month and lives in dread of another major illness. He reports that other small business owners in the area are also unable to obtain insurance and fear the consequences of costly illness.

Ed and Paige Hoffman of Jennings, Missouri, and their 2 children are another family devastated by uninsured illness. Both parents were working full-time for employers that provided no health insurance coverage. Their older child, Eddy, age 7, was seriously injured by a lightning strike in their back yard. Hospital bills for Eddy now total over $200,000, and Mrs. Hoffman can no longer work because she needs to care for Eddy at home. Ed lost his job because he had to take so much time off to be with Eddy in the hospital. He has found work again, but is still uninsured. The Hoffmans rely on charity to help with Eddy's continuing medical needs.

Mr. Joseph Sheppard, of Sparta, GA, works full time as a self-employed house painter, and his wife also works full time. The

Sheppards were unable to afford health insurance. When Mr. Sheppard became seriously ill, they were unable to afford the health care they needed. Mr. Sheppard put off hospitalization until his doctor told him that if he did not have an immediate operation, he would die. He now owes $40,000 for the operation that saved his life.

Families like the Krauses, the Hoffmans, and the Sheppards can be found throughout America, and these numbers are growing. No American family can afford serious uninsured illness.

II. Long-Term Care

Reprinted with permission of Alzheimer's Association ©1985

Alzheimer patient with caregiver.

Senior citizens face a crisis too. They have worked hard all their lives to earn a secure retirement, but their golden years are threatened by the high cost of long-term care. A principal reason why the catastrophic insurance program enacted in 1988 turned into a public policy catastrophe in 1989 is that it failed to provide the protection that senior citizens need most—affordable long-term care.

While senior citizens are especially likely to need long-term care, younger Americans can face the problem, too. The AIDS epidemic, in particular, has exacerbated long-term care needs.

Almost 3 million disabled elderly Americans need home care or nursing home care today. These Americans are unable to perform 2 or more of the basic activities of daily living without assistance—the ability to bathe, eat, dress, go to the bathroom, or transfer from a bed to a wheelchair.

Reprinted with permission of Alzheimer's Association © 1985 (photo by Peter Carroll)

Charles M., a retired physician suffering from Alzheimer's disease, shown with his wife.

Of these disabled elderly citizens, 1.3 million reside in nursing homes. Another 1.6 million are struggling to survive in their own homes, in their children's homes, or in other community settings. As many as 1 million younger Americans are equally disabled.

These figures, as large as they are, dramatically understate the need for a national policy to improve financing of long-term care. According to studies by the Brookings Institution, between 35 percent and 50 percent of today's senior citizens will enter a nursing home at some point in their lives.

Long-term care is not just a problem for the elderly—it is a major burden for their sons and daughters as well. Few families are prepared—either financially or emotionally—to take the responsibility for meeting the challenges of providing long-term care for parents who need it.

The committee heard many examples of Americans and their families suffering from the lack of affordable long-term care. In Los Angeles, Ruth Hanlon described what had happened to her family when her husband John at the age of 50 suffered the first of a series of strokes that left him unable to care for himself. Prior to his illness, John had worked as an engineer for a defense contractor; Ruth was employed as an executive secretary.

Ruth initially wanted to remain in her job, but she could not afford the cost of a caregiver for John. Today, she is no longer employed, and the family has lost a farm, a car, and is $18,000 in debt. But, as Ruth said, one of the most serious costs of John's illness is not measured in dollars and cents, but in stress from the

loss of "normal, everyday activity" that comes from having full responsibility for care of a loved one without any assistance.

Joan Baity of Sandersville, GA, told the committee of the strains created by the need to provide long-term care for a parent without assistance—in this case caring for a mother with Alzheimer's disease. In Ms. Baity's case, that strain broke up her marriage. Today, she is unable to work because her mother needs full-time care. Her only relief is when other family members take over her care responsibilities for brief periods, so that she can go shopping or go to church.

The lack of long-term care is also a serious problem for the health care system. In New York, the shortage of hospital beds is so serious that it is common for patients to stay in emergency rooms for 3 days before they can be admitted to an inpatient bed. More than 1,000 hospital beds in the city are occupied by people who could be better cared for in nursing homes or through home health care, if such assistance were available.

III. Rising Cost of Health Care

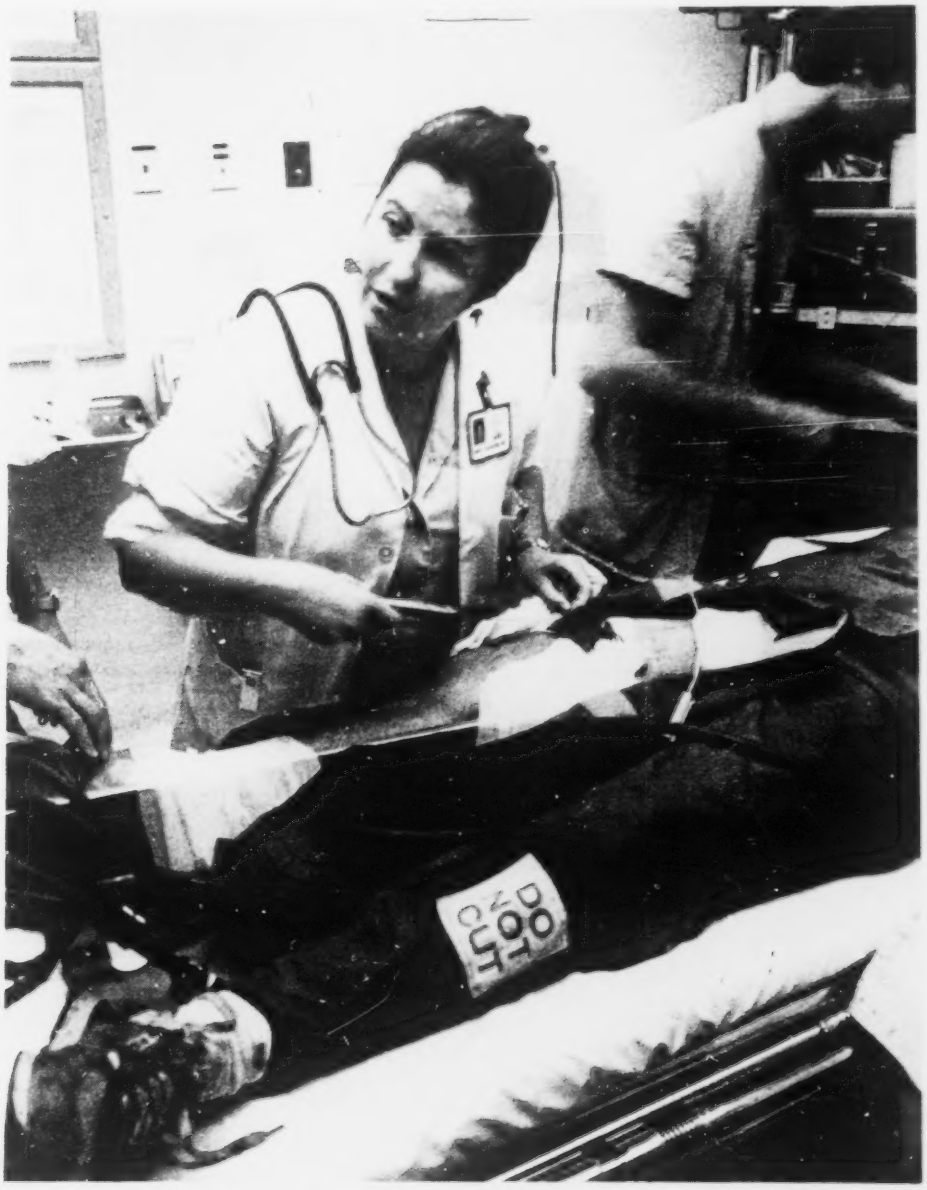
The rising cost of health care and the unfair way we finance it are placing a heavy additional burden on the system. The national bill for health care today is $600 billion—more than double what it was in 1980. Health costs are rising twice as fast as wages. Costs for business have become a flash point in labor-management negotiations, where both sides face a difficult choice between reducing health coverage or reducing wages or profits.

Today, health care costs paid by businesses are 45 percent of corporate operating profits.

Small businesses are especially victimized. They pay 20 to 35 percent more than large firms for identical health insurance coverage. American firms struggling to compete in world markets must bear health costs 40 percent higher per person than in Canada, 90 percent higher than in West Germany, and more than 100 percent higher than in Japan. Chrysler Corporation faces a built-in cost disadvantage of $300 to $500 a car compared to its foreign competitors because of higher U.S. health care costs.

The high cost of health care to consumers was a constant theme in all the communities visited by the committee. In St. Louis, managers and union representatives at a Ford Motor Company plant emphasized the competitive difficulties of high health care costs for the company. In Los Angeles, small businessman Jim Krause was unable to obtain health insurance at any price. Edna Dell Weinel, executive director of the Family Care Health Center in Carondelet, MO, reported that the center's premiums had jumped 52 percent in 1 year, and that the center was able to afford policies for its employees only by including a $1,700 deductible for family coverage.

IV. Failing Financial Condition of Health Institutions



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Emergency medical care being provided to trauma patient: Maricopa Medical Center, Phoenix, AZ.

The previous factors are contributing to the increasing collapse of health care facilities in all parts of the country. No hospital can survive if it cannot receive adequate revenue to cover its costs. Because of the rising number of the uninsured and inadequately insured patients, the burden of caring for those who cannot pay be-

comes heavier every year. At the same time, the lack of adequate long-term care financing and availability forces hospitals to tie up costly hospital beds with patients who could be cared for in less costly, more appropriate nursing home or community settings.

The increasing financial pressure on hospitals is reflected in national statistics. One-third of all rural hospitals are operating at a loss; a recent study by the University of Illinois projected that 600 will close in the near future, on top of the 206 that have closed since 1980. Half of all public hospitals are operating at a loss, and the average deficit exceeds $11 million. According to the Joint Commission on Accreditation of Hospitals, 40 percent of the Nation's hospitals do not meet health and safety standards, largely because of inadequate financial resources.

In every community that the committee visited, the pressures on key health care institutions were clear. In Los Angeles, 10 out of 18 private trauma care emergency centers have closed their doors, because the affiliated hospitals cannot afford to care for the uninsured patients who enter the hospitals through the emergency center. The result, as Robert Gates, director of Health Services for Los Angeles County, told the committee, is that "Anybody who needs trauma care . . . runs the risk that it is not going to be available." In New York, as noted above, many hospitals face a situation where people are kept in emergency rooms for an average of 3 days because no inpatient beds are available. Dr. Gates reported that Los Angeles has had periods "where half the hospitals or more in the downtown areas are not accepting patients." The emergency room at Martin Luther King, Jr., Hospital in Los Angeles was closed for most of August because there was no room. At the New York hearing, Dr. Stephen Lynn of the American College of Emergency Physicians reported that the College had surveyed its national membership and found that 41 out of 50 States reported serious overcrowding in some emergency departments and hospitals.

V. Drugs and AIDS

In addition to these 4 basic aspects of the crisis, drug abuse and AIDS are major complicating factors. The drug epidemic is creating a nationwide demand for treatment services and is exacerbating infant mortality. Hospitals in California are spending an additional 500 million to $1 billion a year to care for the stricken infants of drug dependent mothers. Treatment capacity is sufficient to treat only 6 percent of addicts at any one time. And intravenous drug abuse is quickly becoming the major transmission route for the AIDS virus.

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AIDS patient: San Francisco General Hospital.

Eight and a half years into the AIDS epidemic, there is still no comprehensive Federal plan for responding to this public health emergency. In particular, there is no plan to organize, deliver and pay for the care and the treatment of people with AIDS and HIV disease.

The problem is especially serious, because the Nation is about to experience a rapid acceleration in the rate of new AIDS cases. One hundred thousand cases were diagnosed in the first 8 years of the epidemic, but the next 100,000 cases will be diagnosed in the next 15 months. An estimated 1 million Americans carry the virus but have not yet developed the disease.

The United States spent $1 billion to care for people with AIDS in 1986, and $2.9 billion in 1989—and it will spend $8.5 billion in 1991. In some urban hospitals, beds are already filled with AIDS babies and abandoned infants of drug abusers. People with AIDS are more than 3 times less likely to have private insurance than other Americans. Consequently, AIDS is posing a massive and worsening burden for health care institutions.

The committee found a serious impact of AIDS on the health care system in New York, and even in rural Georgia. Projections

indicate that 80 percent of new AIDS cases next year will be diagnosed outside of New York and San Francisco.

VI. Conclusions and Recommendations

Realistic answers are available to stop this senseless slide and reform our health care system. The question is whether the Nation has the political will to do so now, when reasonable remedies can make the difference, or whether it will wait until the current crisis becomes catastrophic and more drastic surgery is required. The cancer analogy is obvious. The longer we wait to deal with the disease, the more the crisis spreads and the more difficult the cure becomes.

Four major steps should be taken as soon as possible. Proposed legislation to implement these steps is described in more detail in the appendices.

First, businesses should be required either to provide private, job-based insurance to all their employees or contribute to a public program providing coverage. Most workers already get their insurance on the job; all businesses should provide it. It has been more than half a century since the Nation decided that employers should be required to pay a minimum wage, to provide unemployment insurance and to participate in Social Security. As we enter the 1990's, the time is long overdue to require health insurance as well.

Requiring job-based health insurance is not unfair to business. The majority of businesses already do the right thing and insure their workers—and they are at a competitive disadvantage for doing so. They pay more for health care, because others pay less.

Second, a public insurance program analogous to Medicaid should be established for those who cannot get health insurance through a job and are not covered by existing public programs. Premiums should be based on ability to pay. No Americans should be denied the fundamental human right to health care because they are unemployed.

Third, senior citizens and the disabled deserve the same affordable protection against the cost of long-term care that Medicare provides against the cost of doctor and hospital care. No family should be reduced to poverty and no family nest egg should be wiped out by the cost of long-term care. Medicare was the health issue for senior citizens in the 1960's—and long-term care is the health issue for senior citizens in the 1990's.

Fourth, the Nation needs a stronger program to bring health care costs under control.

In addition, these broad system reforms must be coupled with intensified efforts to combat the twin epidemics of AIDS and drugs.

There are some who say that we cannot afford these steps to protect the people. In fact, the Nation cannot afford to ignore this crisis.

According to the non-partisan Congressional Budget Office, the first phase of a program to provide private insurance for workers and public coverage for the unemployed will add $3.1 billion to Federal spending in the year it becomes effective. The first phase would cover 27 million of the 37 million uninsured, including more than 80 percent of uninsured children. The cost of health insurance

for all Americans can be accommodated within the regular budget process by phasing in the coverage over a period of years, without any special source of new revenues.

Long-term care is more costly and will require new revenues. The Congressional Budget Office estimates that approximately $21 billion a year in additional Federal expenditures will be needed. A realistic means of financing the program would be to lift the current cap of $51,300 on wages subject to the Social Security and Medicare payroll taxes. The current cap is regressive and unfair. The wealthiest five percent of employees—those earning more than $51,300 a year—pay a lower proportion of their income to finance these programs than all other workers. Lifting the cap would raise approximately $50 billion a year, more than enough to finance long-term care. The excess revenues could be used to reduce the level of the current payroll taxes.

The $21 billion cost of long-term care should be viewed in the perspective of the current revenue obtained from the Social Security and Medicare payroll taxes—$330 billion a year. Long-term care is affordable as part of Social Security and Medicare, and it can be financed in a way that makes these taxes fairer to all Americans.

Those who object to the costs of these programs ignore a fundamental fact: Americans pay for health care and long-term care anyway, but they pay in cruel and irrational ways—by punishing the sick for their illness, by putting people in hospitals who could have been cared for in a doctor's office, by forcing senior citizens who want to remain at home into expensive nursing homes, and by condemning children to early deaths or lives of disability.

Enactment of these inter-related programs is the most effective step we can take to improve our health care system and bring health care costs under control. Early outpatient care will reduce the need for expensive hospitalization. Home care will reduce the need for expensive nursing home care. Broad-based health insurance for all workers will cut health costs for businesses that already provide it by as much as 30 percent. Reform of the insurance market will cut small business costs by 25 percent.

These savings will be immediate, but the groundwork also needs to be laid for long-term system reforms that will reduce the current runaway inflation in health costs. These reforms include encouragement of cost-effective systems of managed care, development and implementation of programs to reduce unnecessary care, new grant programs to States and private organizations to develop additional cost-saving techniques, and establishment of a national commission similar to the Physician Prospective Payment Review Commission to set voluntary cost reduction targets, monitor health care cost inflation, and make recommendations for future reforms.

Enacting this program will not be easy, but everywhere the committee went, it found that the American people are not only ready for comprehensive reform, they demand it. It is the committee's hope that this report will contribute to the creation of the kind of health care system that America needs and deserves.

THE CRISIS IN NEW YORK CITY: THE TWIN EPIDEMICS OF AIDS AND DRUGS ADD TO THE STRAINS ON AN OVERBURDENED SYSTEM

BACKGROUND

AIDS In New York City

According to the most recent CDC statistics, 22,000 New York City residents have been diagnosed with AIDS—and more than 50 percent have already died. The New York City Health Department estimates that there are approximately 200,000 more residents who are HIV-infected, with less than 25 percent currently exhibiting any symptoms. Many of the problems being confronted by New York City today are problems that the remainder of the Nation will face in the next 5 years.

New York City's Health Department recently issued a 300-page "needs assessment" which estimates that the city is facing a total AIDS bill of $7 billion between now and 1993. An additional $700 million will be needed for capital outlays for hospital, nursing home and housing renovation and construction. Because AIDS is steadily expanding into black and Hispanic low-income communities, more and more of the total costs will not be reimbursed by private insurance, but will fall on public sector programs.

The New York City report further indicates that the average AIDS care payor mix is 54 percent Medicaid, 23 percent privately insured, and a minimum of 15 percent uninsured. With less than a quarter of all New York City hospital patients having private insurance, institutions face inadequate compensation for the vast majority of their patients.

Of the 22,400 medical/surgical beds in New York City, nearly 10 percent are filled, at any given time, with people with AIDS. The health department projects that this percentage could double in the next 3 years. The New York City Hospital system operates at 95 percent capacity or more at all times. The average length of inpatient hospitalization for people with AIDS is approximately 21 days—nearly 2 weeks longer than the average hospital stay in New York City. Because of the lack of community and nursing care, New York City AIDS patients have average hospital stays that are nearly 1 week longer than people with AIDS in San Francisco.

The high Medicaid case load has serious fiscal implications for these overburdened hospitals. The National AIDS Commission, in its recent report to President Bush, stated that while Blue Cross paid $102 for a hospital visit by a physician, Medicaid paid only $6.50. On average, hospitals lose approximately 5 times as much on

people with AIDS as on other medical/surgical patients—largely due to aggravated conditions resulting from drug abuse, hunger, homelessness, and the absence of primary health care.

In New York City, 70 percent of people with AIDS enter the hospital through the emergency room. A New York State Health Department survey found over 2,000 emergency room patients being treated at any one time, with 30 percent waiting for beds. This crisis is further compounded by the nursing shortage, as well as by the lack of long-term care options and adequate reimbursement mechanisms. The department projects that 1,000 hospitals beds could become operational virtually overnight if nursing staff were available.

The department also estimates that more than 10 percent of all people with AIDS (and 5 percent of all patients) in acute beds do not require hospitalization, but simply lack alternative care options. While the hospital inpatient bed shortage may be the most visible aspect of the health care crisis, equal attention must be given to the development and operation of long-term care facilities and programs.

The creation of a continuum of care that includes home care, supportive housing, sub-acute care, nursing home care, and a full range of community-based support services will reduce pressure on acute care hospitals and allow for more humane and cost-effective care. This is true not only for people with AIDS but for all people with disabilities and the elderly. The New York City Health Department estimates that a hospital bed costs $800 per day, a nursing home bed costs $300 per day, while supportive housing and home services cost approximately $100 per day.

To accommodate New York City's growing AIDS care needs, the department projects that by the end of 1990, the system will require 1,200 more hospital beds, 625 more nursing home beds, more than 1,500 supportive housing units, and the ability to service 1,250 more home care clients daily.

This will require not only an expansion of the total number of health care facilities and programs available, but also vigilance against restrictive policies that tend to "screen out" people with AIDS. According to the Citizen's Commission on AIDS, only 2 out of New York City's 147 nursing homes currently admit people with AIDS. The committee was also told that some hospitals keep their inpatient AIDS census down by requiring people with AIDS to be placed only in private rooms—thereby limiting access to the vast majority of medical/surgical beds.

The South Bronx

The South Bronx has the greatest concentration of AIDS cases and public costs in the Nation. The committee's field hearing and site visit shed light on the overall need for a more comprehensive Federal response to the AIDS crisis—particularly in the delivery and funding of HIV health care services.

The South Bronx is the poorest Congressional District in the United States. Sixty percent of residents live below the poverty level and nearly half of those families survive on less than $5,000 per year. AIDS and drugs have compounded the chronic lack of

access to essential health and human services. Marginal housing, widespread unemployment, rampant crime and "no way out" for young people seeking education and opportunity make drug addiction appear to many residents to be the only option for reducing the pain and helplessness. AIDS has made all these other problems worse.

Today the South Bronx has the highest per capita incidence of AIDS of any community in the United States. Among individuals who are 25–44 years old, up to 20 percent of the males and 5 percent of the females carry the virus. Ten percent of the Nation's total pediatric AIDS cases and 20 percent of all adolescents with AIDS live in the Bronx. Of the 50,000 intravenous drug users in the Borough, more than half are HIV-infected. Yet, there are less than 7,000 drug treatment slots available.

With over 50,000 AIDS deaths expected in the South Bronx by the year 2,000, there is no way that the acute care needs unleashed by HIV disease can be handled by hospitals alone—particularly those hospitals already buckling under the weight of uncompensated care. Yet the South Bronx—and places like it—have no adequate primary health care system.

For every 100,000 residents in the Bronx, there are only 5 primary care physicians; the national average is 211 per 100,000. For those who have no primary care doctor, the alternative is to show up in the emergency room where they can expect waits measured in days, not hours. Small medical problems that could have been treated early turn into serious problems requiring expensive hospitalization. Once patients recover enough to be discharged from an acute care hospital, they often have no place to go. The South Bronx has severe shortages in low-income housing, in nursing home care facilities, and sub-acute care facilities. For people with AIDS, step-down care beds are virtually non-existent.

The Bronx-Lebanon Hospital Site Visit

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Mayor-elect David Dinkins arriving at site of hearing on the Urban Health Crisis.

The committee selected Bronx-Lebanon Hospital because of the overwhelming problems faced by the surrounding community and the remarkable efforts mounted by the institution to provide comprehensive services to those in need.

With 565 beds and an annual budget of $180 million, Bronx-Lebanon is stretching inadequate resources into a full service medical program for a desperately needy community. State-guaranteed bonds have enabled the hospital to construct a new, 17-story acute care hospital tower which will open this year. A 240-bed skilled nursing facility is scheduled to open in 2 years—with half the beds dedicated to people with AIDS. However, new buildings do not solve the need for operating funds to deliver essential health services. And since 92 percent of those admitted to the hospital are either uninsured (39 percent) or on Medicaid (53 percent), and only 2 percent covered by private insurance, the hospital will continue to lose large sums on the majority of its patients.

Outpatient AIDS Clinic

The hospital is committed to providing comprehensive care to patients with HIV disease. Patients are assigned a doctor and social worker when they enter the Bronx-Lebanon Hospital system and this team follows them throughout the course of their illness in both the inpatient and outpatient facilities.

Currently, the hospital's 3-day-a-week outpatient AIDS clinic is hectic and overcrowded. But, amidst these conditions, patients are obtaining AZT, receiving aerosol pentamadine treatment to pre-

vent PCP pneumonia, and are being followed by case managers and social workers trying to find essential services covering everything from housing to burial assistance.

The director of the outpatient facility, Dr. Kathy Anastos, was trained in social medicine at the University of California. She accepted her current position knowing that she would be working to provide health services to one of the most disadvantaged populations in America.

The hospital has aggressively pursued special grant programs to expand the array of services available to people with HIV disease. Through a grant from the Robert Wood Johnson Foundation, Bronx-Lebanon has been able to build a community-based consortium capable of delivering a full range of outpatient primary care services to many of the HIV-infected persons living in their area.

The outpatient program works closely with a unique organization known as Project BRAVO—the Bronx AIDS Volunteer Organization. BRAVO helps to coordinate volunteer services from church-group meal programs to activities of other support groups. The program is funded by the United Hospital Fund and the New York City Health Department and continues to gain recognition in the community.

The hospital has attempted to make the fruits of bio-medical research accessible to individuals in the Bronx. It was recently selected by the National Institute for Allergy and Infectious Diseases for a grant as part of the Community Programs for Clinical Research AIDS initiative. With this assistance, primary care physicians at Bronx-Lebanon and their patients will be able to participate in clinical studies of experimental treatments for AIDS and HIV disease.

In addition, Bronx-Lebanon is a distribution site for the Federal low-income treatment assistance program designed to bring FDA-approved therapeutics to indigent individuals who would otherwise be unable to afford these life-prolonging treatments.

In part because of this unique "package" of service programs, patients from far beyond Bronx-Lebanon's service area have found their way to its overcrowded clinic. As far away as San Juan, Puerto Rico, the word on the street among HIV-infected people is that "you can get help at Bronx-Lebanon." The physical setting is utterly inadequate to the need, but somehow the job is being done. In addition, larger clinic facilities, loaned by the New York City Health Department, are due to open in the next few months when the clinic expands services to 5 days a week.

Inpatient AIDS Unit

This 64-bed facility is 1 of 15 hospitals throughout the State designated by the New York State Health Department as a Dedicated AIDS Care Unit, in which the State pays a higher than usual daily rate of reimbursement for care delivered, in recognition of the fact that AIDS patients require an extraordinary amount of medical attention and skilled nursing care during acute episodes of illness. In this unit, patients are also seen by a case manager/social worker who attempts to address essential non-medical issues that will affect the patients and their family. Because 90 percent of the pa-

tients are intravenous drug users, discharge planning and follow-up support are critical. Because of the difficulty in finding both shelter and appropriate level of services outside the hospital, the average length of inpatient stay is 42 days (a month longer than the average length of stay of people with AIDS in San Francisco.)

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AIDS patient Jerry Ruiz, social worker Jossie Rigal, and his mother, Anna.

On the day of the committee's visit, 23-year-old Jerry Ruiz was being cared for by the unit. He was admitted to Bronx-Lebanon shortly after his release from a New York State prison in the summer. Since then, he has lost 50 pounds, been stricken with blindness, and currently lies comatose in his hospital bed. His mother Anna, who earns $4 an hour as a production line worker, has come from Puerto Rico to help care for her son. She comes everyday to feed him and stay by his side. Her greatest worry now is whether she will have the funds to take Jerry home to Puerto Rico for burial. **[Shortly after the committee's visit, Mr. Ruiz passed away due to complications of the AIDS virus and was buried in Puerto Rico.]**

NEW YORK CITY HEARING: AIDS, DRUGS, AND THE URBAN HEALTH CARE CRISIS

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Citizen witnesses testify at hearing on Urban Health Care Crisis: (l.-r.) Jose, Josie, Fernando and Guy.

The New York City hearing focused on 3 panels of witnesses who discussed the health care crisis from their individual vantage points. Panel 1 consisted of people with AIDS who told personal stories about their lives, their health challenges and their search for needed services. Panel 2 consisted of "frontline responders" in the battle against AIDS who told of their attempts to provide critical care with inadequate resources amidst "war zone conditions."

Mayor-elect David Dinkins testified on Panel 3. He re-affirmed the need for a Federal partnership with metropolitan areas plagued by the twin epidemics of AIDS and drugs.

Panel 1: People Living With AIDS

Fernando is a 31-year-old intravenous drug user who was born in Puerto Rico to a middle class family. His mother is a teacher and his father is a police officer. He is the youngest of 7 brothers. He used IV drugs for 14 years, but never "thought he could get AIDS." Fernando did not live on the streets; he had a job, a home, and a family. He always considered himself a "clean junkie"—meaning he had his own injection equipment and did not share them with other addicts—"except maybe once or twice."

Fernando stated that everybody in the shooting galleries knows the four letters A-I-D-S, but that most junkies don't think it can

happen to them. Denial, hopelessness, and addiction are all obstacles to reaching the thousands of individuals who pack the galleries in the Bronx.

Now living in a residential drug rehabilitation program, Fernando has been "clean" for several months. He says that he is glad that he now knows that he has AIDS, so that he can seek the services he needs to stay alive. He states, that most people on the streets will not find out "until it's too late." Too late in this instance means that many drug users with AIDS are now dying on the streets and in abandoned buildings, while others show up in emergency rooms with multiple infections and in the final stages of life.

Fernando receives Medicaid assistance because he now has full blown AIDS. Most of his past jobs did not include health insurance for employees—but he was "healthy in those days anyway."

Fernando's wife knows that he has AIDS and is supportive of him and his search for treatment. He stated that he was initially worried that when he told her he had the disease, she would leave him and take the children. She now attends the support group at Bronx-Lebanon for spouses, friends, and family of people with AIDS.

His 2 children, ages 6 and 10, do not know about his illness. Fernando quietly says that he just does not know how to tell them. He sadly admits that he is scared about their future, and saddened by knowing that he may not be a part of it.

Fernando believes that he has cleaned up his lifestyle and is doing everything possible to take care of himself—but he is still concerned that he is soon going to die of AIDS. He frequently comes back to the importance of his family. One of his biggest worries is where the money will come from to permit him to "die with his family" in Puerto Rico. Although he acknowledges that health care services for people with AIDS in Puerto Rico are extremely scarce—AZT is available for only 20 out of the 3,000 people with AIDS—he wants very much to be with and support his family.

Fernando is the youngest of 7 brothers, all of whom became infected with HIV through drug use. He testified that 3 brothers have already died of AIDS in Puerto Rico, and one was seriously ill at the time of the hearing. Fernando is a soft-spoken gentle person who, for now, takes 1 day at a time. His story is all too common in the South Bronx.

Jose was in his second decade of intravenous drug addiction. Now recovering from his drug use and caring for HIV disease, he wanted to share the need for, and the power of, hope. He talked about life on the streets—about his sense of helplessness and hopelessness. He spoke of begging for change, eating from garbage cans, sleeping in alleys, and only after several days remembering to go home—for money and a shower. It was during one of these visits that his 14 year old daughter told him, "I don't want a drug addict in my house, especially when that addict is my father." According to Jose, "when you need a fix—nothing else matters." Because the physical and psychological addiction is so strong, Jose believes that most drug addicts "don't want to accept reality, don't want to know, and don't want to deal. They want to believe that there is only one way—my way—drugs!"

Jose noted that drug users often "must hit rock bottom" before they are jolted into getting help. He says that an addict must be ready to seek treatment for himself. Jose acknowledges that he initially sought entrance into a residential drug rehabilitation program as a means of securing a warm place off the streets for the winter. It was then that he tested positive for HIV infection. Jose says that when he found out, he was "shocked. It was too much to handle, 2 problems in 1, I thought for sure I was going to die."

Jose now believes that testing positive for HIV "saved his life" rather than ending it. With the assistance of the drug rehabilitation program and the outpatient clinic at Bronx-Lebanon, he has been "clean for 7 months" and is putting his life back together. He compared it to being a child attempting to learn how to walk. He recognizes that "drug addicts do a lot of damage to their families—I did a lot of damage to mine." While they have reconciled, he says that it must happen "step-by-step" and that he has worked hard to gain his daughter back. Jose now works as a volunteer on the AIDS inpatient unit at Bronx-Lebanon—to share the hope and the help he has found.

Guy has transformed his HIV crisis into a tool to make significant positive changes in his life. While he used drugs of all kinds for many years, he is now a program coordinator at the Resurrection Drug Treatment Center in the Bronx. He spoke of the number of times that he sought help, only to be told to "come back next month, come back in 1990." Now he is getting a "view from the other side"—where he has "to tell 20 people a day" that the program has no room.

Guy consistently reiterated that "drug use and AIDS go together"—and that if not attended to, either one or both will kill. He says that "for every 10 people that I see come into the treatment center, I would put my heart into it that 7 are HIV-positive." But because of the lack of drug treatment and AIDS prevention and care services, "they go back to the galleries" where HIV continues to spread "from one to one to the next guy."

Guy believes that if more drug rehabilitation programs were available, more drug addicts would seek assistance. He is also convinced that if health care and social services are not available for addicts who test positive, most will be overwhelmed by the dual diseases and utterly unable to cope. "It's like a bomb being dropped—most will just run for cover and look for any escape."

Panel 2: Professionals On The Front Line

Dr. Jerome Ernst is Bronx-Lebanon's chief of AIDS medical services and head of Infectious Diseases and Pulmonary Medicine at the hospital. He is an effective advocate for getting whatever he can for his patients. At Bronx-Lebanon, since the epidemic began, he has pressed for the creation of patient-oriented outpatient and community-based health services. Under his guidance, this overworked institution developed a model program that integrates medical services with case management, social workers services and community support. However, Dr. Ernst and Bronx-Lebanon are able to deliver comprehensive services to only a tiny fraction of those in need in this community.

Dr. Ernst describes Bronx-Lebanon Hospital as "the epicenter" of the AIDS and drug epidemics. "The rate of AIDS cases in the Bronx-Lebanon catchment area is more than 500 per 100,000 people; the national average is 14.2 per 100,000. Over 20 percent of our inpatients and 15 percent of our outpatients test positive for HIV. One out of every 11 babies born here test positive. About half of these infants will become ill of AIDS. Almost 30 percent of men aged 20 to 35 that are hospitalized here for reasons that have nothing to do with AIDS test positive. So do 12 percent of women in this age group."

This rate of infection is projected to kill more Bronx residents by the year 2000 than all American lives lost during the entire Vietnam War. Against this tidal wave of poverty and disease, the hospital attempts to do as much as it can for as many as it can. Says Dr. Ernst of discharging his desperately poor clients: "First we have to find them a place to live, then we have to get them a phone installed, or the Visiting Nurses won't agree to make a home visit; then we have to assist them in getting Medicaid, line up their home care and then we can begin thinking about discharging them. Frequently, the patient dies in the hospital before all of these arrangements can be made."

While many hospitals in New York City and elsewhere seek to reduce costs by restricting admission of AIDS patients, Medicaid patients, and the uninsured, Dr. Ernst speaks with pride of the open-door policy at Bronx-Lebanon. "We do not turn away AIDS cases, or any patient, regardless of their ability to pay. While other institutions fear damage to their images by caring for AIDS patients, as if caring for the sick could possibly damage a hospital's image, this hospital has reached out to needy patients and is constantly extending its limited resources to meet the challenge. It is our hope that the success of Bronx-Lebanon in addressing the problems of the needy can serve as a model for other hospitals throughout the Nation."

Dr. Ernst nevertheless acknowledges that the hospital needs considerable assistance in order to survive and to continue to meet even a small portion of the devastating needs of the community. Because of the decaying neighborhood and because so many of Bronx-Lebanon's patients are "tough cases," it is difficult for the hospital to find personnel. Dr. Ernst says that they have been trying to recruit house doctors for over a year, and that they now have openings for 6 social workers in their AIDS program. In endorsing the idea of National Health Services Corps, Dr. Ernst said: "American trained doctors must accept the responsibility of caring for their fellow citizens. This epidemic is the most important medical fact of the past and next decade. If we are lacking doctors, something is terribly wrong with our system of education."

Dr. Ernst stated that as treatment options improve and AIDS becomes a chronic illness, service needs will increase. He regrets that there is presently no place for him to send his most seriously ill patients and those who could benefit from stepped down nursing home care. This is a result, he says, of both "societal and fiscal barriers." While he is anxious to see the opening of the hospital's 240-bed nursing home, he agonizes over how he will care for his patients in the 2 years it will take to build the new facility.

Dr. Ernst concluded his testimony with an impassioned plea for Federal assistance. "We need Federal disaster relief. Our Federal Government appropriated $3.5 billion for San Francisco 8 days after that terrible earthquake that killed 60 people. Less than 1 percent of that amount, $35 million has gone to care for AIDS in San Francisco, a disaster that has killed nearly 5,000 residents of that city.

"Our community is in crisis. AIDS is just another blow. Crime, drug abuse, single-parent families, teenage pregnancy, poverty, all of these are endemic here. When one thinks of America—one does not think of the South Bronx. When one views the Government's response to our needs—one does not think of America. Surely we deserve better."

Dr. Stephen Lynn is the director of emergency medicine at St. Lukes/Roosevelt Hospital and chairman of the Task Force on Overcrowding for the American College of Emergency Physicians. More than 150,000 patients pass through Dr. Lynn's emergency department every year. He believes that the crisis in emergency rooms is "widespread and growing." Hospital overcrowding and the resultant clogging of emergency rooms is both "limiting access to emergency care and has the potential to cut the quality of care beyond the margin of safety." It is clear to him that with half or more of the emergency room staff and equipment providing inpatient intensive care—as is the case in most New York City emergency rooms—new incoming emergencies cannot be adequately attended.

Dr. Lynn stated two causes for this crisis: shortage of resources and expanded need for emergency care. In terms of resources, Dr. Lynn pointed to the critical need for more hospital beds, nursing home beds, and outpatient care facilities. And each of these health care options, he emphasized, is dependent on trained nurses to provide the array of health care services. With nursing job offers at a premium, New York City hospitals—often considered war zones—are having a difficult time finding and keeping qualified nurses.

In addition, Dr. Lynn stated that the emergency care system was buckling under the weight of the increased number of patients. He pointed to the American Hospital Association's estimate that 90 million Americans would seek care in emergency rooms during 1989—an increase of 10 percent. Dr. Lynn explained the increase as a function of the growing number of poor and uninsured Americans who lack access to primary health care.

If the uninsured receive any health care at all, it is generally when their illnesses reach an aggravated state and they are forced to seek help in the emergency room. Dr. Lynn adds, "I cannot overemphasize the effect of poverty, AIDS, and drug abuse as adding substantially to the increased number of patients entering the health care system through the emergency department. AIDS may be the straw that breaks the camel's back."

According to Dr. Lynn, the crisis conditions currently faced by New York and Los Angeles will spread to the rest of the Nation over the next several years. In fact, the survey by the American College of Emergency Physicians reported severe hospital and emergency room overcrowding in 41 out of 50 States. Dr. Lynn reiterated the report's conclusion: "The problem we see today seems to be increasing in scope and scale and extending beyond the confines

of the inner city into the suburbs and into the rural areas as poverty, AIDS, and drug abuse move out of the city as well."

Dr. Lynn cautioned against the naive belief that the emergency room crisis only affects those without health insurance. He referred to the emergency department as "the great equalizer. If society thinks that this is a problem that only affects the poor, it is wrong—it may be dead wrong. If a hospital or an emergency department has no bed, whether the next patient who comes through has no home and not a dollar in his pocket, or whether that next patient is capable of purchasing the hospital, if there is no bed available—that patient will wait."

Dr. Lynn stated that fundamental reforms are required to avert a breakdown of the entire system. In his view, the most important task is to insure that all individuals have some type of health coverage—health care must be a "right and not a privilege." Dr. Lynn also believes that we must revamp the system of reimbursements to hospitals, which currently acts as a disincentive for delivering care to the most critically ill patients. Finally, he said, the Federal Government needs to take action to train more health professionals—particularly critical care nurses—and to construct and operate more and varied health care facilities. "Senator Kennedy, as we look to the future, we join your fervent hopes that peace and enhanced security will allow us to redouble our societal investment. The place is health care. The time is now!"

Panel 3: The Local/Federal Partnership

Mayor-elect David Dinkins began his testimony by recognizing those who have dedicated their lives to giving hope and care to people with HIV disease. He acknowledged the sadness involved in watching young people die and applauded those who, despite incredible odds and limited resources, keep at it. Mayor-elect Dinkins also stated that as AIDS continues to expand into minority communities, black and Hispanic leaders, such as Bronx Borough President Fernando Ferrer and himself, must continue to be visible and vigilant in "getting the word out" and developing support for comprehensive prevention and care programs.

Mayor-elect Dinkins asserted that "what should be perfectly clear is that in New York City we are fighting a dual epidemic: AIDS and drugs. Our fight must be on both fronts." The mayor-elect estimated that as many as 90,000 drug-using males and 30,000 drug-using females in New York City are already HIV-infected. While such numbers are numbing, the mayor-elect said that "we cannot just close our eyes like it is going to go away."

Mayor-elect Dinkins stated that "AIDS and drugs have not alone created a crisis, but, rather, exposed a chronic weakness in our health care system." He recalled that there are 2.5 million New Yorkers without any form of health insurance, 1.4 million of whom live in New York City. He further stated that 25 percent of the uninsured are children, 42 percent are minorities, and 66 percent are employed or are dependents of an employed person. It is this growing number of New Yorkers who are disproportionately affected by the dual epidemics. The mayor-elect also pointed to the "clear con-

nection with poverty, unemployment, homelessness, inadequate education, and discrimination."

Acknowledging the overwhelming needs of the poor in New York City as well as the fiscal constraints, the mayor-elect pledged to work with all levels of Government and the private sector in order to provide critically needed services. He offered to work cooperatively with New York State Health Commissioner David Axelrod on a State plan to provide universal health coverage to all New Yorkers and with Senator Kennedy on his Basic Health Benefits proposal. In addition he stated: "Senator Kennedy's AIDS agenda affords us a unique opportunity to support a proposal that covers many critical aspects of the HIV/AIDS epidemic, including, targeting emergency relief to localities most severely impacted by AIDS, like right here in New York City; supporting community-based services which represent the front line of defense against AIDS; creating transitional and supportive housing for homeless people with AIDS as the most humane and cost effective response; providing financial assistance to those individuals that are chronically disabled to maintain the health and social services they need to deal with AIDS and drugs; and a call to revitalize the National Health Services Corps and the VISTA program as a means of expanding the health and social services personnel to fight these dual epidemics."

Finally, in closing, Mayor-elect Dinkins affirmed his willingness to continue to be an activist for the needs of the people of New York City. "I pledge to be a leading player in a city, State, and Federal effort to demand that New York City receive the necessary dollars to save lives, because no life is expendable. And I will work aggressively to join other leaders in those localities hardest hit by the AIDS epidemic so that we can be one voice in Washington. We will go to Washington and we will bring our Federal representatives to New York City so that they can also hear the voices of those who need their help. Our city and Nation are rich with the talent to combat AIDS and drugs and improve a failing health care system. I intend to work very hard in support of initiatives like the Kennedy plan that will work for this city and improve the quality of life for all."

Mobile Medical Van and Meeting With Religious Leaders

Following the hearing at Bronx-Lebanon Hospital, the committee visited the "Project Street Beat—Mobile Medical Unit". Project Street Beat is a program operated by Planned Parenthood of New York City, and the medical unit is funded by the Gannett Foundation. Project Street Beat is a pro-active, community-based, outreach program targeted at runaway and "throw-away" youth who are living on the streets and who are involved in or at risk of becoming involved in prostitution and IV-drug use, and therefore at risk of HIV-infection.

The Health Department estimates that there are more than 3,000 IV-drug users between the ages of 12 and 17 in the South Bronx. Eighty percent of Bronx students drop out of high school before graduation and 46 percent of these youth remain unemployed. One out of every 7 teenage girls in the Bronx becomes preg-

nant each year and nearly half carry their children to term. It is the most alienated of these young people that Project Street Beats hopes to reach.

The medical van is a 31-foot mobile health and education facility designed to deliver health care and support services to street children on "their own turf," since these children are never going to pursue traditional service programs.

The medical unit is a constant presence in the community—particularly in the evening when large numbers of youth are on the streets. Establishing a basis of trust is the first task and the key to success. The staff is committed to providing practical, non-judgmental assistance to those who have little faith in the system.

They begin by providing warmth, a shower, food, clothing, and medical screening—and gradually attempt to integrate these youth into the full range of care networks. Larry Billick, the project director, believes that one step at a time, they can make a large difference.

LOS ANGELES: THE HEALTH CARE CRISIS ON THE WEST COAST

BACKGROUND

Health Care In Los Angeles

The second city visited by the committee was Los Angeles. The site visits and hearing focused on the problems of families without health insurance and those struggling with the costs of long-term care; the collapse of the Los Angeles County Trauma System from the growing number of patients who lack health insurance; and the impact of the lack of prenatal care, drugs and AIDS on children.

Geographically, Los Angeles County is the largest metropolitan area in the United States; with 8.6 million people it is the second largest in the country in terms of population. Los Angeles County includes 86 incorporated cities. As a metropolitan area, it has severe contrasts. Despite the wealth of some regions, 24 percent of the children live in poverty. Despite one of the highest ratios of physicians to population, 27 percent of all non-elderly adults and 30 percent of children are without health insurance. Despite the dreams of childhood portrayed at Disneyland, a black child born in Los Angeles is more likely to die within the first year of life than a child born in Singapore, Cuba or Costa Rica. Among the 20 largest metropolitan areas in the United States, Los Angeles has the largest percentage of uninsured adults and the second largest percentage of uninsured children.

The problem of lack of health insurance is more severe in California than in most States. According to Health Access, a coalition of California organizations dedicated to affordable health care, more than five million Californians—21 percent of all people under age 65—were uninsured during all of 1985. The number of uninsured in California has increased by 40 percent since 1977, even while unemployment has decreased by 50 percent. Nearly 80 percent of the uninsured are working parents and their children. For them, working no longer provides the self-sufficiency and security long valued in this country. All their hard work does not buy these families freedom from fear of financial ruin as the result of costly illness. To protect a family of 4 by purchasing basic health insurance through the private market, an uninsured worker with a minimum wage job would have to pay a minimum of 35 percent of his income.

In 1982, thousands of Californians lost their eligibility for Medi-Cal, the State Medicaid program, and joined the ranks of the uninsured. Several studies from the UCLA School of Medicine, San Francisco Department of Public Health, and public health officials in Alameda County documented unnecessary deaths, increased ill-

ness and hospitalization, and reductions in health status attributable to the loss of health insurance under Medi-Cal. Another study from the University of California at Irvine concluded that the uninsured suffered a severe reduction in the quality of medical care they could obtain when compared with those with health insurance.

The growing number of residents without health insurance has adversely affected the trauma system. When the system was established in Los Angeles County in 1983, 23 private and public hospitals were designated as trauma centers. These facilities were judged best equipped to care for the most serious trauma victims, and their locations around the county were chosen to assure that trauma victims could be transported in the least amount of time. In addition to the 23 designated centers, most hospitals in the county continued to operate basic and comprehensive emergency rooms.

Over the past 7 years, 10 of the private hospitals originally designated as centers have withdrawn from the trauma system, largely as a result of the growing number of uninsured patients. Of the 13 hospitals that continue to participate in the system, 3 are operated directly by Los Angeles County and one is a children's hospital. The private hospitals that have withdrawn have done so for financial reasons; they cannot afford to continue to incur heavy financial losses due to the lack of health insurance of trauma patients.

With a population spread over more than 4,000 square miles, trauma patients in Los Angeles County are now at much greater risk. The surviving trauma centers are not spaced around the county in a way that allows rapid transportation for serious trauma patients. And the centers remaining in the system are severely overburdened. Emergency room visits at the Harbor-UCLA Medical Center in Torrance have increased by more than 30 percent over the past 3 years. The trauma center at Harbor-UCLA was closed 30 percent of the time in August 1989, because of the large number of trauma patients. The center at the King-Drew Medical Center in South Central Los Angeles was closed 70 percent of the time in the same month, because of the near continuous overload of serious trauma patients.

Child Health

Children are our most precious national resource. But the Nation's children are increasingly vulnerable to illness and even death, because of lack of access to necessary health care services, and because of drugs, AIDS and other problems. Many of these problems are related to the high proportion of children who live in poverty. In California, 1.5 million children, 21 percent of the total, live in poverty. In Los Angeles, the figure is 24 percent.

One measure of children's health status is the infant mortality rate—the number who die in their first year of life per 1,000 live births. While the overall rate for California, 8.9 is better than the 10.0 rate for the United States as a whole, the rate among black infants in California, 16.2, is nearly twice as high. In Los Angeles the overall rate is 10.1, and the rate among black infants is a shameful 21.2. The factors that contribute to infant mortality are

multiple and complex, but lack of prenatal care, substance abuse among pregnant women, AIDS and lack of access to necessary health care services significantly affect this problem.

In 1988, over 170,000 births occurred in Los Angeles County—34 percent of the births in California, and 4.3 percent of those in the Nation as a whole. Of the total births in the county, 44,500—26 percent—took place in one of the clinics and hospitals operated by the County Department of Health Services. This number is 28 percent above the capacity of the county system.

Recognizing that one of the major sources of the increase in services needed in Los Angeles County stemmed from the unpredictable arrival of undocumented aliens and the ever-growing number of uninsured and underinsured working poor, the California State Legislature responded in 1988 by passing legislation which provided Medi-Cal coverage to all financially qualified women for emergency and pregnancy-related services, and by increasing the income eligibility level to 185 percent of the Federal poverty level.

However, provider participation—both by hospitals and physicians—in the Medi-Cal program has deteriorated during the decade of the 1980's, so that access to needed health care services for these newly eligible women remains severely limited. The failure of Medi-Cal reimbursement levels to keep up with escalating costs—combined with a burdensome payment system and delayed payment of billings, legal liability concerns, and high malpractice insurance premiums—has driven most hospitals and physicians out of the Medi-Cal program, and left them with such an unsatisfactory experience that even recent attempts to increase the reimbursement levels and improve claims processing have not been successful in inducing sufficient numbers of providers to return to the program.

Currently, the problem of access to prenatal and maternal services in Los Angeles County is at crisis proportions. The great majority of private hospitals are unwilling or unable to accept additional uninsured patients or even patients with Medi-Cal coverage. The resources for expanding the availability of prenatal care in public sector facilities are stretched to the limit. County hospitals and clinics are operating far beyond their safe and rational limits, with department chiefs desperately seeking means to handle the influx of high risk patients.

Two hospitals that are part of the Los Angeles County Department of Health Services provide dramatic examples of the impact of the growing population of uninsured women in need of prenatal and maternal services. The King-Drew Medical Center in South Central Los Angeles, serves a predominantly black and Hispanic patient population. The Department of Obstetrics and Gynecology delivers over 8,000 newborn infants each year. It is the second largest such service in the State of California and the seventh largest in the country. The proportion of pregnant women who receive prenatal care has significantly deteriorated since 1978. In that year, 8 percent of the women who delivered at King-Drew reported no, or had unknown, prenatal care. By 1988 this group had grown to 33 percent. Among black women, the proportion who have had no prenatal care before delivery has increased from 30 to 50 percent over the past 5 years.

The significance of lack of prenatal care can be seen in the impact on perinatal mortality—the rate of fetal and newborn infant deaths. Seventy percent of the perinatal mortality comes from the group not receiving prenatal care, as do most of the premature infants that require extended periods of care in the high cost neonatal intensive care unit. The reasons that women deliver at King-Drew without having received prenatal care are similar to those recently reported by the Institute of Medicine. In a survey of patients completed in 1986, 35 percent reported financial barriers, 25 percent reported transportation problems, and 20 percent reported lack of child care. Only 10 percent reported that they did not think prenatal care was important.

The Harbor-UCLA Medical Center, located in Torrance, serves a mixed ethnic population. The facility has the capacity to deliver 6,000 newborn infants per year. Increasing demand has resulted in a 31 percent increase in the number of newborn deliveries since 1984, and, in 1988, 7,272 infants were born at Harbor-UCLA. Because the postpartum ward cannot accommodate the increased patient census, the average stay following delivery has decreased from 3 days in 1984, to 30 hours in 1986, to 12 hours in 1989. The average risk of patients on the labor and delivery service has been progressively increasing, so that 85 to 90 percent are high risk patients.

Harbor-UCLA is overwhelmed by the growing number of patients and the provision of prenatal care is severely strained. The average waiting time for an appointment to begin such care is 4 to 10 weeks. As a result an increasing number of pregnant women arrive in labor without having had prenatal care.

The problem of substance abuse, especially among pregnant women, has also contributed to the worsening health care crisis in Los Angeles. In 1985 approximately 500 babies were born addicted to illicit drugs. By 1986 there were almost 1,000 such babies, in 1987 over 1,500, and in 1988 over 2,500. At this rate, 1991 will yield over 10,000 drug-intoxicated newborns delivered in Los Angeles County. Alarming as these numbers are, they underestimate the true magnitude of substance abuse during pregnancy. Many private hospitals do not report their cases of neonatal drug withdrawal; some of these women intentionally deliver at home or in birthing centers in order to avoid being identified as substance-abusing mothers. Although, drug-exposed during gestation, many newborn babies will have no clinical or laboratory evidence of drug exposure at birth if the mother has not used drugs during the 24 to 48 hours prior to delivery.

In Los Angeles County, as with most urban centers, cocaine is the No. 1 drug problem. At the Harbor-UCLA Medical Center, the prevalence of cocaine intoxication among pregnant women at the time of delivery increased 35 times between 1983 and 1987. From 1986 to 1989, the number of newborn infants with evidence of cocaine intoxication nearly doubled, with one-third of these infants born prematurely and nearly 30 percent with low birthweight. A decreasing proportion of substance abusing mothers receive prenatal care—43 percent in 1986–1987, and only 18 percent in 1988–1989. Thus, many preventable problems such as congenital syphilis

go untreated. Eight percent of drug intoxicated newborns were born with congenital syphilis in 1988.

Site Visit To The Pediatric Failure-To-Thrive Clinic at Harbor-UCLA Medical Center

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Families and patient at Failure-To-Thrive Clinic, Harbor-UCLA Medical Center.

The Harbor-UCLA Medical Center is 1 of the 4 hospitals in the Los Angeles County Department of Health Services. The hospital has 750 beds, and the Pediatrics Clinic had 27,000 patient visits in 1988. The patient population is 40 percent Hispanic, 20 percent black, 2 percent Asian, and the remainder Caucasian.

The Failure-to-Thrive Clinic is held once a week and is staffed by physicians, nurses, developmental specialists, nutritionists, social workers and psychologists. Patients in this clinic represent children who have sub-optimal growth and development due to nutritional and other problems, including prematurity and low birthweight, chronic illness such as cancer, child abuse and neglect, prenatal exposure to drugs, and AIDS. Care of these children is difficult because of complex medical problems compounded by poor family and social support systems. Most of these children would have a greater probability of normal lives and good health status had their mothers received prenatal care, avoided abusing drugs, or been successful in preventing infection with HIV.

During the visit to the clinic, the committee heard from mothers, foster mothers and children who have "failed to thrive." Fern Buchanan is a foster mother to 2 children who are HIV-positive. The youngest child is 2 years of age, but his height and weight are comparable to a child only 15 months of age. He was born to parents who are both prostitutes. He was HIV-positive until 18 months of

age, and is presently HIV-negative; he is considered to be free from infection of the AIDS virus. Even so, he has had several hospital admissions and his development has been slow. The oldest child is 4 years of age. He was born to a drug-addicted mother. He is HIV-positive, but has been healthy in recent months. Mrs. Buchanan discussed the added difficulty of caring for children who are HIV-positive. She also stressed the importance of providing a caring and loving home for these children, and her satisfaction in knowing that she is giving these children some amount of security and happiness.

Penny Raymeyer is a foster mother caring for a child who acquired AIDS from a blood transfusion. Denise Harrington is HIV-positive and a mother of a 16 month old with AIDS; the child's father died from AIDS last summer. Mayra Gonzalez is the mother of a 10-month-old daughter who acquired infection with HIV prenatally. Each of these mothers described their difficulties in obtaining adequate care.

Dr. Jim Seidel, chief of Ambulatory Pediatrics and Pediatric Emergency Medicine; Dr. Rosemary Leake, chief of Neonatology; Dr. Carol Berkowitz, acting chairperson of Pediatrics; and Dr. Charles Brinkman, chairman of Obstetrics and Gynecology discussed the growing difficulty experienced at Harbor-UCLA and throughout Los Angeles in caring for the growing number of patients without health insurance and with the added problems of drug abuse, lack of prenatal care and poor health status. Dr. Brinkman noted the growing burden on county facilities because of the refusal of private physicians and hospitals to care for poor women who have only Medi-Cal insurance coverage or no health insurance at all, and because of inadequate reimbursement for services and escalating medical malpractice insurance premiums. Ed Foley, chief executive officer at Harbor-UCLA, stressed the crisis the institution faces in having to care for an increasing number of seriously ill patients in the face of shrinking resources provided by the County and State Governments, and the greater number of patients without health insurance.

Site Visit To The Emergency Room At Harbor-UCLA Medical Center

The Harbor-UCLA Emergency Room has been increasingly overburdened because of the withdrawal of private hospitals from the Los Angeles County trauma system. In 1988, the Harbor-UCLA emergency room had 150,000 patient visits, up 33 percent since 1985. Because of rising drug and gang-related violence, the severity of trauma seen at Harbor-UCLA and other Los Angeles' emergency rooms has increased significantly in recent years.

Because of the growing burden on Harbor-UCLA, patients who need admission to intensive care units and other inpatient beds are forced to remain in the emergency room, because other beds are not available. Dr. Robert Hockenberger, chairman of the Department of Emergency Medicine, related several instances of critically ill patients in need of intensive care who remained in the emergency room for as many as 3 or 4 days because of the lack of beds. During the committee's visit to Harbor-UCLA, a patient was being

maintained on a respirator in the emergency room because the medical intensive care unit was filled to capacity; this patient had been in the emergency room for more than 24 hours. In addition, the nursing staff told of patients remaining in the emergency room for 1 to 2 days and receiving kidney dialysis.

Dr. Carl Stevens, director of quality assurance in the Department of Emergency Medicine, discussed potential and actual compromises in the quality of patient care in the emergency room because of the significant growth in the number of patients and the declining financial stability of the hospital. While the patient volume has increased, the emergency room has not been expanded, the acquisition of new life-saving technology has been postponed, and the number of physicians and nurses on the staff has been cut. Stress on the trauma system has led to nursing and medical staff "burnout," and it is increasingly difficult to recruit replacements. The experience of working in the Harbor-UCLA emergency room was compared with Vietnam. Dr. Bill Swanson, medical director for Harbor-UCLA, stressed that the greatest contributing factor to the crisis in trauma care in Los Angeles County is the growth in the number of patients without health insurance.

LOS ANGELES HEARING: THE UNINSURED, LONG-TERM CARE, AND THE COLLAPSE OF THE LOS ANGELES COUNTY TRAUMA SYSTEM

To gain a better understanding of the cost and health care access problems of individuals and families without health insurance, the impact on families of the need for long-term care, and the collapse of the Los Angeles County trauma system, the committee held a hearing at the Royalwood Care Center in Torrance, CA. Royalwood is a private nursing home, licensed for 127 beds, whose patients have illnesses and problems typically found in long-term care facilities around the Nation including: Alzheimer's disease, stroke, diabetes, dementia, and other chronic illnesses.

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Residents of Royalwood Care Center, site of hearing on Health Care Crisis on the West Coast.

Jim Krause, the owner and operator of a small printing business in Glendora, CA, testified that in 1986, his health insurance company went bankrupt. Before he could find an affordable policy, he had to go to the local hospital emergency room with a mild case of indigestion. All the tests were negative and he was sent home, having paid all the costs out of pocket.

Mr. Krause applied for health insurance, but it was denied. The company indicated that he had a pre-existing condition—gastritis, or, as Mr. Krause described it, indigestion—for which he had recently sought care in the local hospital emergency room. He was confronted with the same response from other companies to which he applied for insurance.

Subsequently, Mr. Krause suffered a small stroke—a transient ischemic attack—and spent a few days in the hospital. This experience brought him face to face with the reality of the high costs of medical care. As Mr. Krause said, "So after 2 CAT scans at $650 apiece, x-rays and other exams, one night in the ICU, the hospital bill came to $3,300. We paid $1,000 down and started making payments. But no one could find anything wrong. My doctor suggested we take further tests. I asked how much, and he said about $4,500, and I had to tell him no."

During 1987 he tried to obtain health insurance from several companies, but it was denied because of pre-existing conditions. He approached the group of businesses in the small shopping center where his printing shop is located and sought to organize the purchase of a group policy, but this effort was unsuccessful.

In January, 1988, Mr. Krause suffered a major heart attack. After a 2-week hospital stay, and the insertion of a permanent cardiac pacemaker, he was left with a $42,000 hospital bill. He paid $4,500 and tried to make monthly payments, which exhausted his family savings. Finally, in November 1988, Mr. Krause filed for bankruptcy. Since then, he has tried to obtain health insurance without success; companies have repeatedly told him that he is medically uninsurable. Because of limitations in his activity after his previous heart attack, he can only work a few hours a day. Mrs. Krause now works full-time, but her employer does not provide health insurance; she is seeking another job that does provide this benefit. Mr. Krause summarized his current position by saying, "We are sitting now without insurance, and if I, or one of us get sick again, I don't know what we will do." Mr. Krause is now seeking to sell his printing business and look for less stressful work.

Senator Kennedy asked Mr. Krause, ". . . do you know of others that have similar kinds of circumstances, similar kinds of problems of not being able to obtain insurance?" Mr. Krause responded, "Yes. There are several in the center where I work at." Senator Kennedy asked, "Do you think insurance ought to be a right for Americans, some form of coverage?" Mr. Krause answered, "Yes, of course."

Carolyn Hanlon is 49 years of age and her husband John is 52 and a full-time resident of the Royalwood Care Center. John has had multiple strokes, is no longer able to speak and requires tube feedings. Mrs. Hanlon cares for her 71-year-old mother at home;

her burden of long-term care spans 2 generations. She gave her testimony with her husband at her side. John Hanlon worked for a large defense contractor until 1987, when he suffered his first stroke. Since that time he has not been able to work and his health and functional status have deteriorated. Even though insurance has covered most of John's medical expenses, the family has still had to pay approximately $12,000 in out-of-pocket costs, and they are $18,000 in debt. They were able to purchase their first home in July, 1987; it took 5 years to save the down payment of $20,000. John first became ill in August, 1987; his initial hospital bill was $37,000.

John's illness has devastated the family. Prior to his illness, Mrs. Hanlon had worked as an executive secretary. But as John became increasingly disabled, she had to begin full-time care of her husband. As Mrs. Hanlon related, "One of the other reasons why I had to quit my full-time employment was because it was costing $800 a month to have someone come in and take care of John. I couldn't afford $800 a month, so I came home to take care of him myself. And then he had more strokes and went into a board and care place last December, and that was $1,000 a month." Four months later, John had to be transferred to the Royalwood Care Center.

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John Hanlon, a patient at Royalwood Care Center. John's wife, Marilyn, a witness at field hearings is seated behind him.

With the help of John's remaining health and disability insurance and Medicare, the $3,000 per month cost of care at Royalwood has been covered.

Mrs. Hanlon has applied for Medicaid to cover these costs when their other funds are exhausted in the next 3 months. If John does not qualify for Medicaid, Mrs. Hanlon does not know where she will obtain the resources to maintain John's care.

Having to care for her frail, elderly mother at home, Mrs. Hanlon is only able to work part-time. She has been able to support herself and her mother only because of John's disability payments, her mother's Social Security and her meager income. She would like to become a court reporter to provide more income and security for herself in coming years.

Asked whether she would like to increase her income, Mrs. Hanlon responded, "Certainly, because I am only working 4 hours a day now. I only bring home $100 a week, and that is because of my own stress that I have to cope with. And I am planning to go back to school next February. I will have to go nights. And hopefully I can establish another career. My income—any income that I have right now—is the result of John being employed all those years. Should anything happen to John, I certainly won't have any more income, and I have to be ready to support myself."

Mrs. Hanlon described the emotional depth of the impact of her husband's illness. When asked about what the most difficult part of caring for her husband has been, she replied, "It is a very personal and very abstract thing, but it is coping with the denial. It is going to a marriage counselor because something is wrong with your marriage and you can't figure out what it is, and nobody suggests going and getting a physical. And you find out that what is wrong with your marriage, your husband is brain damaged from strokes. And it was the loss of him. The loss of him in my daily life." **[Several weeks after the hearing, John Hanlon died after suffering another stroke.]**

Donna Van Tassell is a 54-year-old black woman. She and her husband and sister cared for her mother, Mrs. West, who suffered from Alzheimer's disease, for 7 years. Mrs. Van Tassell's mother died in October, 1989. Her mother had no savings of her own when she moved in with the Van Tassells, and was receiving approximately $300 a month in Social Security. Despite the fact that Medicare covered many of her medical costs, the Van Tassells had to spend most of their life savings for the costs of prescription drugs, in-home nursing care, ambulance and other health-related costs for Mrs. West. The Van Tassells had almost $30,000 in savings before Mrs. West came to live with them in 1982; today they have less than $4,000. The family income has fluctuated between $15,000 and $20,000 for the past 7 years.

In 1986 Mr. Van Tassell was laid off from his commission-based job at Montgomery Ward, and the family lost their health insurance. All of their own medical costs are now out-of-pocket, including $4,000 in breast surgery that Mrs. Van Tassell required.

The Van Tassells have had to come to grips with the consequences of rising health care costs without insurance. As Mrs. Van Tassell explained, "My husband and I began to realize that we needed help and so we asked my sister to move in to help me a little bit, and help with some of the finances because my mother didn't have any supplemental insurance, so we had to pick up what Medicare didn't pay. And her medicine was quite expensive, and so

she decided she would move in. But after the surgery, we got a lot of bills from the doctors because a lot of them didn't accept assignment, which I didn't realize and know anything about, because I wasn't into Medicare right then, but I learned fast."

The Van Tassells recognized that they were fighting a losing financial battle in their efforts to care for Mrs. West. Mrs. Van Tassell related, "I saw that our utilities and things became higher because she (Mrs. West) was there every day. We had quite high utility bills, and I would try to burn our fireplace to kind of cut the bills down on gas, because it was quite expensive . . . by 1986, our lifestyles began to really change—financially and socially. . . . Developers had come in and started buying homes around us, so that meant they were building apartments and things up around our home, and so we had to make a decision to try to maybe move so that we could have a quiet, decent life . . ." Before they could purchase another home, Mr. Van Tassell was laid off. He has not been able to find another job, and now works sporadically as a jazz musician.

A few months before Mrs. West died, the Van Tassells moved her to a nursing home because caring for her at home became too difficult. Through all of this, the Van Tassells have been devastated. Mrs. Van Tassell explained, "We had a lot of financial expenses that were hitting us, our payment for our home was quite high and we had a life savings—our savings are depleted now. But my mother died October 6 and now I am trying to get my life back together. I am trying to go back into the work force so I can help my husband, and so I can get some hospitalization or some health insurance for us."

Panel 2: Professionals On The Front Line

Robert Gates, the director of health services for Los Angeles County, was the first of the second group of witnesses at the hearing. Dr. Gates provided an overview of the imminent collapse of the trauma system in the county. His depiction of the deterioration of health care services in Los Angeles heightened the sense of crisis portrayed by the first 3 witnesses.

The Los Angeles County Department of Health Services includes 6 hospitals and 48 health centers. The department has an annual budget of $1.6 billion and provides 2.9 million outpatient visits per year. Twenty-five percent of all the newborn infants born in Los Angeles County are delivered in one of the Los Angeles County hospitals.

In the 1980's the Los Angeles County Department of Health Services has significantly reduced hospital and ambulatory services due to budget cutbacks. Funds from the State have been drastically reduced, at a time when the demand for services has increased because of the growing number of patients without health insurance, and the large immigrant population. In addition, the trauma system has been described as near collapse because of the withdrawal of 10 private hospitals originally designated in 1983 as part of the 23 hospital trauma network. This has lead to the overburdening of those hospitals remaining in the network, typically

public or teaching hospitals, and to increased ambulance transit times for critically ill patients.

Mr. Gates identified the lack of health insurance as the primary problem contributing to the difficulties experienced in Los Angeles: "The underlying problem of this and a couple of other problems I'll mention is essentially the lack of insurance coverage, where we have something like 25 percent . . . of the people in the State [that] don't have health insurance, and that is particularly focused in the downtown area of Los Angeles. So we have a lot of problems facing the hospitals, the trauma centers, because they are collecting these poor patients into their systems and not being reimbursed . . ."

Mr. Gates continued, ". . . at one point this was considered a problem of the poor people, and now it's affecting everybody in the county. Anybody who needs trauma care or in the central core area emergency care, runs a risk that it's not going to be available because of this lack of insurance coverage . . . we have large areas of the county that simply don't have a trauma center within close range for anybody."

Mr. Gates described the elusive practice of "patient dumping" that hospitals are continuing, despite laws and regulations that require them to care for all emergency patients in need of care: ". . . in the downtown area we have been seeing situations where again due to lack of coverage, hospitals have either closed or threatened to close their emergency rooms, or something more subtle . . . that hospitals simply become closed and divert ambulances away from their facility . . ."

Mr. Gates also discussed the worsening crisis relating to obstetrical care; "Another situation that's facing us now that is increasingly serious, has to do with obstetrical care. It's another form of emergency services, and we're seeing a greater and greater number of mothers coming into our system to give birth to the point where we're projecting something like 46,000 visits in our 4 hospitals that have OB services compared with a rated capacity of about 35,000 . . . Some of this relates to an increase in the total number of births in the county, but it also seems to relate even more to a shift from the private sector to the county . . . Physicians are so disgusted with all the procedures and all the hurdles for payment and low payment rates, that they are not particularly interested in remaining in that (Medi-Cal) program. And once again, the county ends up picking up the burden."

When asked whether the Los Angeles County Department of Health Services has the capacity to care for all the uninsured, Mr. Gates replied, "No way. No. That's not a capability we have. In the past we have had to rely on the private sector, and the private sector has provided a great deal of charity care so-called, and something needs to be done to maintain that kind of capability."

The next witness, Captain Gene McCarthy, described the growing stress and strain placed on the trauma system in Los Angeles. Captain McCarthy has been the paramedical coordinator for the Los Angeles County Fire Department for 3 years. Before this, he served as a front line paramedic for 13 years. Captain McCarthy is also the past president of the California Rescue and Paramedic Association.

In addition to the closing of 10 of the original 23 trauma centers since 1983, the demand on the trauma system has grown tremendously. In 1970, before the establishment of the trauma system, there were 12,000 emergency calls made to paramedic units. In 1989 there had been 130,000 calls up to the date of the hearing. Summarizing the problems of the emergency medical system in Los Angeles, Captain McCarthy stated, ". . . our EMS system is having a heart attack, and what it needs is an IV of money . . . As we find the population increasing and the people are poorer and sicker, and drug abuse is rampant, and more violence in the street, we find ourselves behind a rock. We need some help."

Echoing Captain McCarthy's words of warning, Bob Hook, a Los Angeles County Fire Department paramedic described a trauma system near collapse: "We get a critically ill victim, we have no trauma center . . . you get somebody that's very critically ill that needs that trauma center, we have to take them to a hospital that may have only one physician on duty, and a nurse. They're not going to get the proper care, but we have no trauma center to take them to. And it's worse and worse."

The final witness was Dr. Jacques Sokolov, vice president and medical director for the Southern California Edison Company, the second largest electric utility in the United States. Dr. Sokolov discussed the need for expanded employment-related health benefits; equitable payment levels across all payers; cost sharing and utilization controls; and equitable financing mechanisms. Dr. Sokolov also described the managed health care system established at Southern California Edison for its 54,000 employee family members; with this system they have been able to guarantee access to care for all their employees and their families.

Dr. Sokolov described the attitude at Southern California Edison, ". . . Edison is not just interested in its small universe of 54,000 people. We believe that from a business standpoint, large corporations need to take an active role in terms of their responsibility on some of the issues that have been discussed here today. We believe that for the most part, we do need to have a universal access program . . . We believe that there are 4 components in terms of looking at the access issue that are critical. We think that No. 1, there should be an expansion of employment related health benefits. Inclusion of employee cost sharing and utilization control mechanisms once this access is provided [is the second component]. Establishment of a uniform provider payment level [should also be included] . . . And then, fourth, there has to be an equitable financing mechanism . . ."

THE CRISIS IN ST. LOUIS: THE VIEW FROM MIDDLE AMERICA

BACKGROUND

The committee's visit to St. Louis was designed to focus on the effect of the health care crisis on middle Americans.

St. Louis has a population of 2.5 million people with a population growth of 4.8 percent throughout the 1980's. Unemployment stands at 5.5 percent. The greater St. Louis area, while slowly making a transition to white-collar occupations, still relies on blue-collar labor and manufacturing for its economic livelihood. Major employers are in manufacturing, auto assembly, aerospace, chemicals, and food and beverages.

Missouri Health Care System

Missouri has one of the finest health care systems in the country, with a concentration of major hospitals in the St. Louis area. Several factors highlight the advantages that St. Louis residents have over people living in other areas of the country:

- Missouri expanded Medicaid to include pregnant women and children to age 3 years at 100 percent of poverty level;
- A program for the prevention of mental retardation reimburses hospitals for certain high risk conditions of pregnant women and their infants;
- Missouri Crippled Children's Services diagnoses and treats specific problems of children; and
- Hospitals which serve a disproportionate number of poor receive higher reimbursement rates.

Uninsured And Underinsured Population

Despite its leadership in health care, a study on indigent health care prepared for the State of Missouri showed that 1 in 5 residents is either without any health insurance or has inadequate coverage. This problem places a strain on the medical system throughout the State. The uninsured and underinsured population includes those who are without any private or public insurance, non-elderly low-income persons with inadequate health insurance, low-income elderly with Medicare coverage but no other insurance for other expenses, and persons above 150 percent of the poverty line who incur out-of-pocket medical expenses in excess of 10 percent of their family incomes.

Persons in low income families are more likely to be without insurance than those in higher income households. Over one quarter

of all persons in households with incomes below 150 percent of the Federal poverty level were uninsured, as compared with 7 percent of the population above that income level.

Reasons vary for the lack of health insurance, although the most commonly cited factors include loss of job, no coverage on the job, cost, or coverage denied.

Although no studies have been made to show the exact increase in the uninsured and underinsured population, medical providers state that there has been an explosive demand for services, particularly charity care, over the last decade. In Missouri, there are a variety of reasons for this explosion, including an overall economic decline, Medicaid cutbacks, layoffs in the automobile and manufacturing industries, and an employment shift to the service sector, which typically insures a much lower percent of employees than manufacturing.

The worsening of the economy in certain areas of the State since 1979 has led to an increase in the size of the uninsured population. The Northeast section of the State, which has one of the highest rates of uninsured persons, is estimated to have had nearly a 50 percent increase in the relative size of its low income population, as a result of the farm crisis that struck the State in the 1980's and that still affects the area today.

The problem of the working uninsured is dramatic. Over 60 percent of the households with an uninsured member reported that the head of the household was employed. Families with a person with a serious medical condition, disability or handicap that required medical treatment or hospitalization on a regular basis had a greater likelihood of having an uninsured member than did the general population.

Children were more likely to be uninsured than adults, while the elderly, because of Medicare, were less likely to be without insurance than the rest of the population.

Many residents of Missouri have health insurance which does not provide complete protection against the cost of illness. Many policies exclude certain services, place limits on what is covered, or require considerable patient cost-sharing. The inadequately insured population falls into 3 groups:

Low income, non-elderly persons with inadequate health insurance;

Low income, elderly persons covered by Medicare who lack supplemental private insurance or who are not also covered by Medicaid; and

Persons who do not meet the definition of "low-income," but who are inadequately insured and at risk of becoming medically indigent if they incur catastrophic expenses as a result of a serious illness or accident.

Poor and uninsured families encounter problems in access to health services more often than other segments of the population. Over one-fifth of all families with incomes below 150 percent of poverty reported they had problems such as needing care but not receiving it, being refused care by providers, relying on charity

care or being unable to pay their medical bills. Thirty percent of households with uninsured members encountered access problems.

Hospitals And Primary Care

The uninsured and underinsured population is placing a heavy burden on primary care and hospital providers across the State. The amount of uncompensated care provided by Missouri hospitals increased over 110 percent between 1980 and 1988. In 1988, the Missouri hospitals provided $374 million worth of uncompensated care—more than $1 million per day. This jeopardizes the financial stability of the entire system. Since 1980, 7 public hospitals in the State have been sold to private organizations, while another 4 have closed.

Primary Care

Continuous and comprehensive primary care reduces more serious problems of disease and disability when it is geographically and financially accessible. Yet, increasing health care demands are placing a growing burden on primary care providers throughout the State.

Primary care providers are faced with 2 major problems:

Increasing numbers of uninsured are seeking medical treatment at primary care facilities; and

More underinsured people who do not have coverage for primary care are forcing community health centers to cover the co-insurance and the deductible for the more expensive hospital and tertiary care.

Because of growing demands, health centers are being forced to deny assistance to an increasing number of patients. Many people forego medical treatment until the illness or disease progresses, forcing them to seek more expensive care at a hospital. One of the witnesses who headed a community health center stated that her facility had to refuse treatment to over 2,000 patients last year.

The financial strain on hospitals throughout Missouri has forced them to close their primary care facilities and placed an additional burden on the community health centers to which patients are often referred.

Employers

Employers who do provide health insurance for their employees are facing higher costs because other employers do not provide such coverage. When uncovered employees seek and receive charity care, costs are passed on in the form of higher charges to insured patients. Those higher charges, in turn, result in higher insurance premiums for employees.

Employers who do provide benefits are also covering spouses who are employed in firms which provide no coverage. This, too, raises the cost of the insurance they provide.

For employers in Missouri, the costs of coverage have significantly increased year after year. Heavy manufacturing health costs increased 11 percent from 1986 to 1987. In light manufacturing, the

increase was 15 percent, and in the service and financial sectors the increase was 18 percent for the same time period.

This is not a recent or isolated development. Since 1973, the Consumer Price Index increased 166 percent. Yet national health expenditures increased 429 percent and the health costs of business increased 602 percent. This impact is most severely felt by manufacturing firms, which must compete in the global economy with foreign enterprises not facing such severe health cost burdens. Escalating health costs also discourage firms from providing health coverage if they must compete with domestic rivals that decline to insure their workers.

Malpractice Costs

Because of the rising malpractice premiums, Missouri physicians are changing many of their practices and increasing their fees. They are adopting more conservative practice styles, avoiding high-risk patients, reducing the number of Medicaid patients, refusing to accept new low-income patients, and electing not to provide care in local health department-sponsored clinics.

Missouri's recently enacted malpractice reform legislation is expected to slow the rise in malpractice premiums. However, considerable damage has already occurred in term of access of low-income people to physician care, especially access by pregnant women to prenatal and obstetrical care. The State is concerned that it will experience increases in its infant mortality rate and expenditures for low-income children with disabilities that could have been prevented with adequate prenatal and obstetrical care.

Overview

Missouri is facing a crisis similar to other States across the country. The sophistication of the health delivery system places the State at an advantage and enables it to serve many of the large numbers of uninsured and underinsured poor and working class citizens. But the system will not tolerate the strain much longer. Medical and Government leaders recognize that reforms must occur to avoid the collapse of the system and improve access to necessary health care for all Missourians.

People's Health Center, Maplewood

Senator Edward Kennedy and Congressman William Clay visited the People's Health Center in Maplewood, a small working class community located just to the West of St. Louis.

The center serves 3,500 patients a year, with the demographics generally reflective of the area it serves. Sixty-two percent of the patients are white and 35 percent are black. Seventy-one percent of the patients are below the poverty line, and an additional 24 percent are between 100–200 percent of the poverty level. Forty-six percent of the patients have no health insurance, 32 percent have Medicaid coverage and 13 percent have Medicare. Sixty-two percent of the patients are female.

The services provided at Maplewood focus on preventive health care. Obstetrics, gynecology, internal medicine, podiatry, and pediatrics are among the typical specialities represented.

The center is staffed by 6 physicians, 2 full-time and 4 part-time. Two registered nurses and 4 assistants are also on the staff. The center generally operates Mondays through Fridays from 8:30 a.m. to 5:30 p.m., with evening hours on Thursdays.

During the center visit, the center was conducting its normal schedule. The waiting room was filled with patients awaiting their appointments, and there was a steady movement into the waiting area by new arrivals from the street entrance.

Several patients spoke to Senator Kennedy and Congressman Clay about their health problems and their lack of insurance. A surprising number of those without insurance were employed, several on a full-time basis.

While the center conducted its business in an efficient manner, the demand for service clearly outstripped the center's ability to provide it. The staff reported that new patients often could not be treated. From their perspective, the demand for services was greatest among those lacking health insurance, and the ability to provide these services decreased as the amount of uncompensated care increased.

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Elderly patients at People's Health Care Center.

ST. LOUIS HEARING: WORKING PEOPLE FACE THE HEALTH CARE CRISIS

Following the site visit to the Maplewood People's Health Center, Senator Kennedy and Congressman Clay held a hearing at the Maplewood Baptist Church to obtain a first-hand account of the health care needs of St. Louis, MO, a representative city in a representative mid-Western State.

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Citizen witnesses at hearing on the Health Care Crisis for working people: Edward and Paige Hoffman, Neal Baretta and Brigett McDaniel.

PANEL 1: CITIZENS

Brigett McDaniel, a student and part-time worker, told of the inadequacies of student insurance and the dilemma posed for young couples unable to afford private care or qualify for subsidized care. Two years ago, she was diagnosed as having sarcoidosis, a malfunction of the immune system. She incurred $7,000 in medical bills as a result of hospital and physician treatment. She discovered that her student insurance plan covered only a third of the bills for treatment. Under her insurance, only one treatment per accident or disease was covered. Future treatments were the responsibility of the insured. In Brigett's case, she required prolonged treatment, and without adequate health insurance, she could not afford the care she needed.

She was constantly harassed by collection agencies, who rejected her offers of monthly payments. She "explained to them my financial situation and I was told that I needed to make a minimum payment of $150 to $200 a month to get this paid off, and that I should have thought about this before receiving treatment." As a result of the limited coverage, Brigett was unable to afford to see a private physician. She was forced to seek treatment at an emergency room, and was referred to a clinic that agreed to treat her at a minimal cost.

Although her husband recently began working full-time and will soon be eligible for health insurance, Brigett will be excluded from the coverage because of her pre-existing condition. She also expects to be denied the less expensive clinical care because her husband's income of $12,000 will exceed the local guidelines.

Brigett is caught in the middle of a health care dilemma that prevents her from obtaining health insurance because of a pre-existing condition. She is unable to afford the high cost of private care without insurance, but her husband's income will disqualify her from receiving subsidized care.

Neal Baretta has an 11-year-old son, Jason, born with cerebral palsy and epilepsy. The Barettas are typical of many working families who cannot obtain insurance.

When Jason was first diagnosed, his medical bills were covered by insurance through Neal's job. Neal was subsequently laid off and the insurance ceased. When he attempted to obtain other insurance for his son, numerous insurance companies told him that there was no coverage available for Jason because of his pre-existing condition, although they were willing to insure other members of the family.

Jason was later hospitalized with seizures at the age of 9 months, with costs of $40,000. The Missouri Crippled Children program paid for all of the costs directly related to the cerebral palsy and epilepsy, but the program will not cover Jason for any other injury or disease. The result is that if Jason is injured in any way, the family must pay the entire cost.

Jason's parents have responded to the problem by limiting his activities. He cannot play baseball, football, soccer or ride a skateboard because of fear of injury. The medical bills that would be incurred from such an injury could be financially disastrous to the family.

Neal Baretta summarized his feelings about the injustice of the system by saying, "How do you tell an 11-year-old boy that he can't do normal things? . . . His neurologists say Jason is normal. He has a slight problem; he has seizures. They're controllable by medication but insurance companies . . . won't insure you. They won't even talk to you, but he's still normal."

The health problem posed by the Baretta family is faced by families of epileptics across the country. Epilepsy can be medically controlled, but in a majority of cases, insurance companies deny coverage. As a result, people with this condition face daunting medical bills not only for their epilepsy but for other health problems that occur.

Edward and Paige Hoffman told the committee about the difficulties faced by a young working family when tragedy strikes a child. Their 7-year-old son, Eddy, was struck by lightning in the summer of 1989. The near-fatal accident required him to be hospitalized for 7 weeks, with 4 weeks in intensive care. He incurred severe brain damage, and his parents were told that he would have to be fed through an IV tube and would remain in a vegetative state for the rest of his life. Upon release from the hospital, Eddy returned home. He breathes on his own, is fed through a tube and is confined to a wheelchair. He is able to say a few basic words, but he has no motor function, and requires constant care.

At the time of the accident, both parents were working. Edward Hoffman was employed full-time at a vending company and Paige Hoffman was working in 2 part-time jobs as a hairdresser and waitress. None of the jobs provided health insurance.

Paige Hoffman was forced to quit both jobs to care for Eddy when he came home. In discussing her decision, Mrs. Hoffman said that "the only option they (physicians) left to us was either to pull the plug on his life support system and take our chances, or institutionalize him. Eddy was always a shy and quiet child; he's not going to respond to somebody he doesn't know."

Edward Hoffman was fired from the job he had held for 12 years as a result of the amount of time he spent at the hospital. Congressman Clay noted that Mr. Hoffman's experience demonstrates the need for parental leave legislation, which would have protected Mr. Hoffman during the time his son was hospitalized.

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Congressman Clay listens to witnesses at the St. Louis field hearing.

The Hoffman's medical bills exceed $200,000. The cost for Eddy's month-long stay in the intensive care unit, was $3,800 a day. Some of the private services and doctor bills, which amounted to $15,000, were paid through a trust fund established by the local police department and community. United Way is helping to pay the cost of the medication and therapy.

The availability of the trust fund and the Hoffman's ownership of a new van caused Medicaid to deny the initial request for eligibility. The Hoffman's have sold the van and are in the process of

reapplying for Medicaid assistance. Without Medicaid, they have no hope of paying their overwhelming medical bills.

The Hoffman's situation illustrates how a young working family can be devastated by a tragedy beyond their control. The fact that none of the jobs which they held had health insurance reflects an increasing trend. More and more employers are providing part-time positions, because they do not want to provide benefits, including health coverage. Other employers are eliminating health insurance altogether in order to reduce costs. Without health insurance or an adequate Federal program to cover medical costs, families like the Hoffmans will never be able to pay medical bills that will continue to increase throughout a lifetime of disability for a family member.

Panel 2: Professionals On The Front Line

Betty Jean Kerr is director of the People's Health Centers, with facilities in St. Louis and Maplewood, serving a working and poor population, many of whom lack health insurance. She spoke about the role of federally funded community health centers in providing health coverage for the low and moderate income population. Nationally, over 600 community and migrant health centers are the main source of health care for nearly 6 million Americans, including 1.5 million women of childbearing age and 2 million children.

Last year, the Peoples Health Centers provided services to 15,000 patients in 60,000 visits. Ms. Kerr spoke about the barriers that uninsured and underinsured individuals face in maintaining their health, including limited access to care, inability to comply with drug therapy, a reluctance to use primary and preventive health services and reliance on the emergency room as a regular source of care.

Of the population served at the People's Health Centers, 30 percent of low income patients have no public or private health insurance—and more than half of the uninsured (16 percent of the total) are employed. Fifteen percent of the employed individuals have inadequate health insurance coverage which excludes primary care services or drugs or places high deductibles on such care. Eleven percent are elderly Medicare beneficiaries who lack supplemental health insurance and are not covered by State programs. The clinic also treats inadequately insured persons who are not low income but are at risk of becoming medically indigent if struck by high costs of illness or accident.

Ms. Kerr stated that "there's no real debate about the fact that the lack of affordable health care has reached crisis proportions affecting all of us. Uninsured and under-insured people suffer with serious untreated health problems—often because they avoid seeking health care from traditional institutions until an emergency crisis arises."

Discussing the dilemma that working people are faced with, Ms. Kerr stated that Medicaid eligibility in Missouri requires individuals to meet income standards for cash grant assistance. "Therefore, there is simply no option for inadequately insured wage earners to acquire coverage under the exiting Medicaid program, leav-

ing the purchase of individual health insurance as the only way of protecting against out-of-pocket payments for health care."

Edna Dell Weinel is executive director of the Family Care Center of Carondelet, which serves the working poor and poor of South St. Louis. Two-thirds of the people served make less than $17,500. Although 41 percent of the patients work full-time, only 9.8 percent have insurance.

Ms. Weinel emphasized that many people who have insurance do not have coverage for primary health care. As a result, community health centers are filling the need. She advocated that health care reform include limiting deductibles and co-insurance to secondary and tertiary levels of care, so that all people have access to primary care.

Ms. Weinel noted 3 reasons why many patients at the center are not working—family responsibility, lack of day care for children, and illness. She urged that steps be taken to reduce these barriers to employment by providing increased services and affordable medical care.

The growing number of people seeking care is forcing the center to deny assistance. This year, it turned away over 2,000 new patients. Since there is no place for costs to be shifted, the center has to pay all the medical costs of the patients. Ms. Weinel cited this fact as another reason for limiting deductibles and co-payments to hospitalization, since primary care can reduce the need for more expensive forms of care.

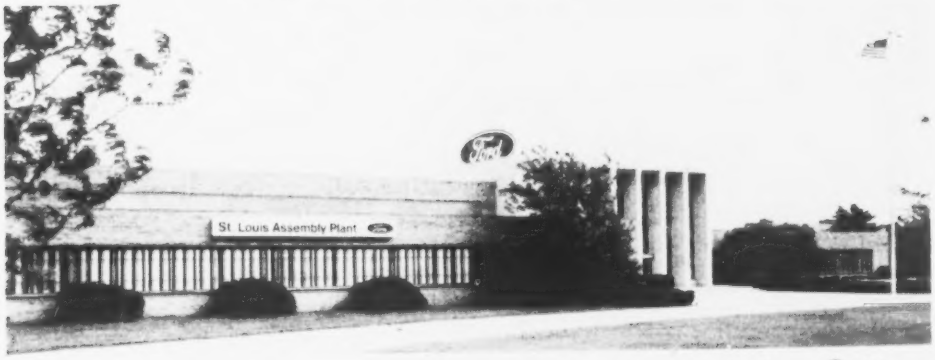
In St. Louis, many city clinics are facing financial crises, including Cardinal Glennon Hospital, one of the major resources for emergency care, which recently closed its primary health care clinic. This action has placed greater strain on primary care providers across the city.

The Family Care Center employs 42 people and is a small business. Ms. Weinel provided figures that emphasized the problem from a small business perspective. This year, the center was paying $122,000 for health insurance for 42 people. Individual deductibles were $700 and the family deductible is $1,700. Their insurance costs increased 52 percent between 1988–1989 because of the use of medical services to care for premature twin babies and necessary surgery for employees.

Because small businesses have difficulty obtaining bids for insurance, they are forced to accept cost increases or face the prospect of no insurance at all. Ms. Weinel emphasized the need for regional pools to reduce health care costs for small businesses. As she stated "I think all employers are like us, in that they aren't necessarily malicious at heart about insurance for people, but the cost is so high."

A major point that was repeated throughout the hearing was summarized by Ms. Weinel: "The major challenge here is that all of us will have to pay one way or another. These patients are going to be seen. They're coming to us sicker . . . (and) feel relatively embarrassed about coming to centers that they feel should support the more under-insured individuals, and they stay home until they are very ill. . . . They end up at the hospitals. The hospital is going to have to bear the costs for these patients which will be cost shifting to the economy or us."

FORD/UAW MEETING, HAZELWOOD



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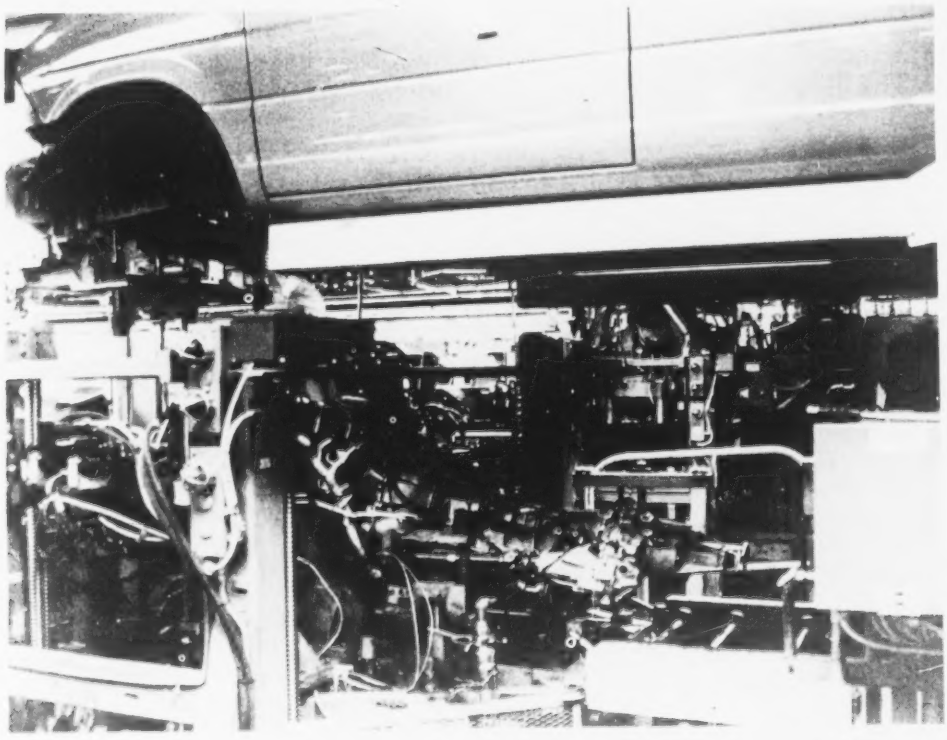
St. Louis assembly plant: Ford Motor Company.



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Factory floor: Hazelwood facility.

After the hearing, Senator Kennedy and Congressman Clay met with Ford management and UAW union officials at the Hazelwood assembly plant. The topic for discussion was the cost of health insurance and the impact on health costs of employers who do not provide coverage for their workforce.

The Hazelwood facility is located 16 miles northwest of St. Louis. Constructed in 1947, it employs 2,700 employees in 2 shifts, and

since 1985 has been producing over 200,000 Ford Aerostar vans annually. The facility has successfully incorporated state-of-the-art technology into its assembly process in its efforts to remain competitive. It also has an "ergonomically designed" assembly line which has significantly reduced back and other lifting injuries to workers.

The meeting revealed an increasing concern with escalating health care costs, and the attendant competitive difficulties in maintaining existing benefit levels.

Representing Ford management were the assistant plant manager, the comptroller, the employee relations manager and the company benefit representatives. Representing the UAW were the local vice-president, the local benefit representative, and several regional representatives.

What emerged from the discussion was an agreement that Ford pays higher costs for its health coverage as a result of other employers' failure to insure their own workers. Heavy manufacturing employers such as Ford, with older work forces, have the highest health care costs per employee of any sector of the economy, and continue to experience double-digit increases in costs.

The health care cost per hour and per vehicle are significantly higher than the costs for foreign firms and this cost disadvantage will continue to be a factor in the company's struggle to remain competitive. U.S. per capita expenditures on health care are 41 percent greater than those in Canada, 85 percent greater than in France, 87 percent greater than in West Germany, 132 percent greater than in Japan, and 171 percent greater than in the United Kingdom.

The union representatives explained the difficulties in maintaining current benefit levels, noting that as health care costs continue to soar, maintenance of current benefits has limited increases in the hourly wages which can be negotiated for employees. While health coverage has been largely protected, it has cost the employees amounts which otherwise could have gone into wages or health employee benefits.

The discussion presented a picture of the dilemma of a good employer, who, with its union, has developed a sound health benefits package. Such employers pay a heavy price as a result of cost-shifting from employers who refuse to provide coverage. This cost-shifting imposes an unfair double burden on employers with sound benefit plans. They pay the health care costs of their own employees—and they are frequently saddled with the costs of other's employees too. The consensus, from both labor and management, is that something must be done, or the competitive position of employers who provide health benefits will suffer further unacceptable erosion.

SPARTA, GEORGIA: THE HEALTH CARE CRISIS IN RURAL AMERICA

BACKGROUND

Rural Health

Seventy percent of the Nation's counties are designated as rural, but they contain only 23 percent of the population. This population faces the same health care problems experienced in other areas of the country, but because a disproportionate number of those in rural America are uninsured, elderly, or poor, they are especially hard hit by the Nation's health care crisis.

A higher percentage of the rural population is uninsured—19 percent of rural compared to 17 percent of urban—and the higher percentage holds for every income level. Only one-third of the rural poor qualify for Medicaid compared to 48 percent of the poor in inner cities.

In Georgia, nearly 18 percent of the population, totaling 1 million persons, is without any health insurance. For rural residents, the figure is 20 percent. More than half of working persons in Georgia between 50 percent and 100 percent of the Federal poverty level are uninsured. Of the State's non-elderly uninsured population, three-quarters are in households where at least one family member is working, compared to two-thirds nationally.

The aging of the national population is particularly pronounced in rural America. Whereas the elderly comprise 12 percent of the Nation's population, they account for 25 percent of the rural population. In Georgia, about 40 percent of the population resides in rural areas, but 48 percent of persons over age 65 reside there. Georgia is ranked 15th in the country in the number of residents over 65.

Seventy percent of the population below the poverty level resides in urban areas, but poverty rates among nonelderly rural residents are nearly 40 percent higher than among urban residents. The rural poverty rate grew throughout the first half of the 1980's, reaching 18.3 percent in 1985, compared to an urban poverty rate of 12.7. Beginning in 1980, the rural unemployment rate consistently has exceeded the urban rate, a reversal of the historical pattern.

With low recent employment growth, rural areas find it difficult to attract new residents. Rural population growth outpaced that of urban areas by an annual average of 30 percent during the 1970's, but dropped to 55 percent of the urban rate during the 1980's.

Infant mortality is a disturbing Nation-wide phenomenon, but the rates are shocking in the South, including parts of Georgia. Nationwide, the average infant mortality rate is 10 deaths in the first year of life for every 1,000 live births. The State of Georgia has an

overall infant mortality rate of 12.5, but the rate is 18 per 1,000 births for blacks, and the State has the 47th worst record in the country for infant mortality. Georgia is also 1 of the 5 top-ranking States for the highest neonatal mortality rate, the highest low birthweight rate, and the highest teenage pregnancy rate among blacks.

The health status reports on rural America challenge the typical view that these citizens have healthier and safer lifestyles. According to data from the 1987 National Health Interview Survey, while acute conditions are equally prevalent in urban and rural areas (1.73 conditions per person), chronic conditions are more prevalent in rural areas (1.78) than in urban areas (1.55). Overall, 18.7 percent of urban residents reported chronic or serious conditions, compared to 23.4 percent of rural residents; 12.8 percent of urban residents reported limitations in activities of daily living compared to 15.7 percent of rural residents.

Hospitals

Since 1980, 206 rural hospitals have closed. Nationwide, hundreds more face serious financial difficulties that could close their doors soon. In 1987, 41 of Georgia's 106 rural hospitals operated in the red. The closure of rural community hospitals can have an especially negative impact on access to health services by the poor and elderly, who are represented in higher numbers in rural areas.

Many of the Nation's rural hospitals were constructed under the Hill-Burton program enacted in the 1940's. This program attempted to assure that all Americans have accessible medical care in their own community. In more recent years, rural economies have changed and rural demographics have shifted as more and more people leave rural areas for opportunities in urban areas. Two of the major difficulties currently facing rural hospitals are that these hospitals have fewer people to serve, and more of their patients are poor or elderly.

In Georgia, the average small rural hospital derives two-thirds of its revenues from Medicare and Medicaid. A factor contributing to the erosion of the financial viability of rural hospitals is Medicare's reimbursement policy. Medicare maintains a payment rate for rural hospitals that, for the same diagnosis, is 12.3 percent lower than the payment rate for urban hospitals. The Medicare program has difficult-to-meet qualification thresholds for assistance on high-cost cases, which are much more difficult for small hospitals to absorb. Hospitals that are a community's sole source of care have also not received adequate financial support from the Medicare program. In 1989, rural hospitals in Georgia expect to receive $26 million less than their costs for treating Medicare patients.

In addition, the current system fails to recognize the vulnerability of low-volume small rural hospitals to a payment system that leaves them at risk for fluctuations in admissions and costs. Since 1980, small and rural hospitals nationally have experienced declines of 42 percent in admissions, 11 percent in the average length of stay, and 32 percent in occupancy rates.

The problems associated with Medicare reimbursement add to the difficulties that most rural hospitals face, but they are not the

major problem. In addition to declining utilization of inpatient services, cost containment pressures by public and private insurers, and increased competition for patients, rural hospitals face special burdens. Smaller hospitals, predominantly in rural areas, do not have the necessary patient volume to take advantage of economies of scale. Higher rates of poverty and greater proportions of uninsured patients undermine their viability. Sole community hospitals and "frontier" hospitals (those located in counties with fewer than 6 persons per square mile) often face substantial costs for infrequently used standby equipment and personnel.

Health Care Personnel

Rural communities have always been plagued by shortages of health care personnel. Inadequate and inequitable reimbursement rates and difficulty in establishing an economically viable practice in areas of low density dissuade many providers from settling in rural areas. Also, a fear of professional isolation and a lack of modern medical facilities, equipment, or local referral directs many toward urban areas. Practicing in a rural area can often be a 24-hour job with inadequate back-up support.

According to the Graduate Medical Education National Advisory Committee, in 1990, the target ratio for physicians should be 191 doctors for every 100,000 persons. For small, rural Georgia counties, the ratio is fewer than 50 physicians per 100,000. The Department of Health and Human Services designates areas as health manpower shortage areas if they have a physician to population ratio of 29:100,000. As of December, 1987, DHHS had designated 786 dental, 562 psychiatry, and 1,944 primary care health manpower shortage areas. Of these designations, 11 psychiatry, 52 dental, and 75 primary care were in Georgia.

Rural communities have often been forced to offer physicians bonuses or guaranteed salaries to induce them to locate there; when that fails, they have relied on physicians placed in their community by the National Health Service Corps, which was established in 1970 to improve health care in shortage areas. NHSC provides scholarships for health professions students, who are obligated to serve in health manpower shortage areas for a minimum of 2 years. The Corps is now only a skeleton of the successful program of the past. Scholarship awards peaked in 1979 with 2,380 new scholarships awarded. The last scholarship was awarded in 1988 and field strength has been declining every year since then. The peak corps field strength of 3,127 in 1986 has fallen so far that the projected level is only 655 in 1991 and 435 in 1992.

In 1987, a new loan repayment program was established. Health education graduates are offered $20,000 per year to repay educational loans for each year of service in a health manpower shortage area, but the new program has not been funded at an adequate enough level to rebuild the corps to respectable levels.

Other sources of health care in rural areas are community health centers, which offer an array of prevention-oriented primary care services to low-income and medically underserved populations. The Federal subsidy of these centers covers less than half (48 percent) of the cost of providing care to this population; the re-

maining costs are covered through Medicare, Medicaid, or fee-for service charges. Of the Nation's 357 community health centers, 65 percent are located in rural areas. Many rural grantees maintain multiple clinic sites, so that the actual number of locations providing services is much greater. Georgia has 15 centers and 30 delivery sites.

Another threat to the availability of physicians in rural areas is the increase in malpractice fees. In 1987, a U.S. Department of Health and Human Services Task Force on Medical Liability and Malpractice found that average malpractice insurance premiums for all specialties increased 31 percent between 1982 and 1985. Over this period, premiums for family physicians increased by 91 percent, and for obstetricians, 113 percent.

Sparta, Georgia

The committee visited Sparta, GA to learn first hand about the rural health care crisis. Sparta is a town of 1,500 citizens approximately 120 miles Southeast of Atlanta. It is located in Hancock County, 1 of Georgia's least developed counties with a population of 9,300 and a limited employment base. The county has 2 textile plants, a small furniture factory, several pulpwood and timber operations, and a few retail stores. The principal agricultural crops are corn, soybeans and sweet potatoes. The county's unemployment rate is consistently above the national average. In addition, over half of Hancock County's residents have to travel outside of the county for employment. The average weekly wage is about $200, and nearly 40 percent of households have an income of less than $10,000 per year. The per capita income in Hancock County is less than 60 percent of the national average.

Despite these serious financial limitations, the citizens of Hancock County have made a strong commitment to maintaining local health care services. In 1985, the county reopened the small rural hospital in Sparta that had been closed for 10 years. The people of the county understood that reopening the hospital would require considerable resources. While the hospital has restored ready access to hospital care, the county has had to commit one-third of its total budget to the hospital. A large portion of these funds provided uncompensated care for indigent patients.

Hancock County is an excellent example of a county facing the broad spectrum of rural health care problems. The people have made it clear that they are willing to make the sacrifices necessary to provide decent health care in their community.

Home Visit

During his visit to Sparta, Senator Kennedy stayed overnight in the home of David and Donna Griffith. Donna is 35 years old. She was diagnosed with multiple sclerosis at 14, an unusually early onset for the disease. The Griffiths married, knowing the kinds of challenges the illness would pose for both of them.

When the Griffiths were first married, Donna was in relatively good health, and she was able to work for a number of years. However, the disease has progressively restricted her activities and she is now confined to a wheelchair.

As Donna's health deteriorated, the Griffiths faced mounting concerns over health insurance. David described his job-hunting procedure as having one primary goal—to find the health insurance plan that would best cover Donna. At present, David's health insurance plan provides primary coverage for Donna, and she receives secondary coverage under Medicare as a disabled adult.

For many years, despite the benefits of comprehensive insurance coverage, Donna needed home health care that was not covered by private insurance or Medicare. It was impossible for David to be regularly available for Donna, since, as for many rural workers, it was a long distance between his job site and his home. Other family members helped as much as possible, but David acknowledged that there were times when he feared being unable to meet his job responsibilities and care for Donna as well.

A technical change in the Medicare home health regulations recently enabled Donna to obtain coverage for home health aide services for 1 to 2 hours a day, 5 days a week. Once a week, Donna receives skilled nursing care. These home health services have, in the Griffths' words, "transformed" their lives. Donna feels a new independence that she has not known for many years; David no longer has to worry about Donna's care when he is at work. Both are gratified that there has been a recognition of the appropriateness of home health service for Donna's condition. They told the committee that they understand how fortunate they are since very few Medicare beneficiaries, either elderly or disabled, qualify for home health benefits.

The Griffiths are an example of how home-based care can work. In their case, a relatively modest change in the health care system produced a profound change in their lives. However, there remains a massive national need for home and community-based care. Only an expansion of public coverage for such services is likely to have a significant impact on the lives of the millions of families of chronically ill people who continue to struggle to obtain adequate health care at home.

Site Visit: Hancock Memorial Hospital

Hancock Memorial Hospital is a 52-bed facility that opened in 1969, but was closed from 1975 to 1985. In the early 1980's, the voters in the county approved a bond issue of $2.5 million to finance the reopening of the hospital. Payment on the bond issue is currently $40,000 per month. The limited access to capital for rural hospitals has meant that the hospital has little chance to refinance the 13.5 percent interest on its bond issue. The county also provides subsidies for the hospital ambulance service, as well as general subsidies for uncompensated care provided by the hospital. Gary Dolack, administrator of the hospital, described operations: The hospital currently has 32 beds in service, with an additional 10 beds ready to provide "swing-bed" service as soon as the State legislature approves Medicaid reimbursement for such service. The hospital employs 88 full and part-time employees. In addition, the hospital has 5 physicians on its staff, all of whom have offices outside of the hospital as well.

SITE VISIT: HANCOCK COUNTY PRIMARY HEALTH CARE CENTER

Senator Kennedy and Congressman J. Roy Rowland visited the Hancock County Primary Health Care Center in Sparta, GA. The center opened in 1983 and receives funding under the Federal Community Health Center grant program.

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Congressman Rowland discusses rural health care issues with Dulcie Moore, executive director of the Hancock County Primary Health Care Center.

Most community health care centers are designed to serve minority and low-income patients, and the primary care center in Sparta is no exception. Most of its patients are black and many are poor. The center employs a sliding fee scale of 0–100 percent based on need. Even with this scale, numerous patients cannot afford to pay the minimum fee of $5 a visit. The center serves approximately 20–25 patients per day, and draws patients from Hancock and surrounding counties. The center has three small examination rooms and a very small laboratory. It cannot perform x-rays or sophisticated tests, but will pay for such services if patients need them but cannot afford them.

Rural community health care centers help to lessen the impact of shortages of primary care physicians such as general practitioners, internists and obstetrician-gynecologists in rural areas. The

centers promote preventive health care, and reduce the inefficient use of rural hospitals as the source of primary care. Without such facilities, many rural residents would go for even longer periods of time without treatment and would require even more expensive medical services when they are eventually forced to seek hospitalization.

The Primary Health Care Center is 1 of 15 centers in Georgia. Although these programs cover only 31 of Georgia's 159 counties, they serve nearly 110,000 Georgians. At present, 82 counties in Georgia are designated by the Public Health Service as Health Manpower Shortage Areas. It is estimated that the State would need at least 160 additional physicians to cover the underserved areas currently designated. In its latest survey in 1986, the State Joint Board of Family Practice found that although almost 40 percent of Georgia's population live in counties with fewer than 50,000 residents, only 16 percent of the State's physicians practice in these counties.

While the need for the services provided by such facilities continues to grow, the principal source for community health care center physicians, the National Health Service Corps has, as discussed above, undergone drastic cuts in recent years. In 1981 $63.4 million was authorized for NHSC scholarships; by 1988 the figure was only $2.2 million.

During the early 1980's, the NHSC brought 25–30 physicians into Georgia per year; in 1989 only 5 new NHSC doctors were brought into the State. Recently, the Hancock County Primary Health Care Center experienced a vivid demonstration of the consequences of this trend. When the center's NHSC physician left in September 1989, there was no replacement. After a lengthy and difficult search, the center was able to locate a new National Health Service Corps physician, Dr. Gene Guy, who did not arrive until early December. For a period of almost 3 months, the center was without a doctor. It is hard to calculate the effect of such a lapse on low-income and medically underserved populations, but in recent years the center's physician was the only doctor employed full-time in all of Hancock County.

So long as there are inadequate numbers of NHSC physicians, one community's gain will be another community's loss. The rural clinic in Florida that Dr. Guy left to come to Sparta has been unable to locate a replacement. Dr. Guy spent his first day off from the Hancock County center traveling back to Florida to see his former patients, who were without a new doctor.

The center's executive director, Ms. Dulcie Moore, who has worked at the center since its opening, stressed the critical role of the primary care facility in providing access by low income patients to quality medical care at an affordable price. Less than half of the patients have health insurance, and Ms. Moore noted the sharp increase in the number of patients from families in which the "breadwinner" has health insurance but other family members do not, because the employer either does not offer or will not contribute to family coverage.

Both Ms. Moore and Dr. Guy discussed the need to attract more doctors to rural areas and retain those already serving there. Recognizing that many young doctors are choosing urban practices,

while large numbers of older doctors are nearing retirement, Dr. Guy expressed his fear that, "the old country doctor is going out of style."

Dr. Guy noted that one of the biggest problems in rural health care is the isolation of patients. The long distances between medical facilities and the absence of public transportation create formidable obstacles to care for rural residents. Here again, community health centers help to address the problem.

Dr. Guy stressed his view that by preventing small illnesses from becoming serious ones, the primary care center serves the whole health care system by keeping costs down. Cuts in the National Health Service Corps or in the services provided by primary care centers not only threaten the advances that have been made in providing care in medically underserved areas, but also threaten to escalate the rise in health care costs.

Dr. Guy emphasized that the major challenge in rural health care in Georgia will be to treat not only traditional chronic health problems, but the "Pandora's Box" of increasing incidences of substance abuse, especially crack, and AIDS. He noted that in his previous practice in rural Florida, he was seeing startling increases in drug abuse and AIDS cases, and a growing number of "crack babies." Dr. Guy also said that there is a clear need for additional primary care services, and that if funding is available, the need for an additional full-time physician at the Sparta center could be met.

SPARTA HEARING: THE HEALTH CARE CRISIS IN RURAL AMERICA

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Witness panel of Sparta, GA hearing on the Health Care Crisis in Rural America: (l.-r.) Joan Baity, Debra Brown and Joseph Sheppard.

Joan Baity from Sandersville, GA described the mental and emotional devastation associated with caring for a family member suffering from Alzheimer's disease. Joan was raised on a farm in Illinois and moved to Georgia in the 1950's. Both her mother and father worked in the cattle industry, which provided them with a steady income but never placed them in a high-income bracket.

In 1980, Joan moved to South Carolina, to be married and to work in the court system. During her occasional visits to Georgia to her parents, she began noticing the confusion and forgetfulness that were the first signs of her mother's Alzheimer's disease. But, as Joan noted, "You do not recognize that (these are signs of Alzheimer's), you think that is senility, you just sort of write it off and keep going."

When Joan's father became ill with cancer in 1986, her mother was initially able to take care of him. But she broke her hip later that year, and needed help herself. The strain of traveling back and forth to care for her parents ultimately destroyed Joan's marriage, and she moved in with her parents to take care of them full-time.

In February 1989, Joan's father died of cancer after an intense 7-month period of decline, during which her mother's mental condition further deteriorated. Joan's mother became occasionally violent, which is common in Alzheimers' patients. Now her mother is bedridden and requires constant supervision. For Joan, who lives alone with her mother and is her primary caregiver, this means 24-hours-a-day care.

Her mother's health expenses are covered only by Medicare. Before her father died, her parents' income level made them eligible for Medicaid. Under the Georgia Medicaid program, Joan's mother was able to receive some home health care. After her husband's death, however, Joan's mother lost her Medicaid eligibility because an increase in her Social Security benefits raised her income above the eligibility level.

Describing the support she received, Joan said, "there are 2 family members who come long enough for me to go to the grocery store and go to church, but as far as having someone else come, you have to pay out of pocket . . . People ask me what I'm doing. I believe what is said in one of the commandments: 'Honor thy Mother and thy Father.' If mother were to go into a nursing home, we could not afford it. Anyway, she would die of loneliness, as many elderly people do in nursing homes. I don't want this for her."

Asked what would make the difference to her in terms of being able to care for her mother, she said, "An afternoon a week, just an afternoon a week."

Debra Brown, a divorced mother of 3 children who lives in Greensboro, GA, testified about the difficulties she has faced in obtaining health insurance protection for her 7-year-old daughter, Shondell, who suffers from acute asthma.

Ms. Brown and Shondell have had to deal with this chronic illness for many years; Shondell had one of her worst asthma attacks when she was only 2 years old, and was hospitalized in an intensive care unit for almost 2 weeks. At that time, Ms. Brown was for-

tunate in that she and her husband were both working, and they had health insurance coverage that paid most of the medical bills.

Understanding the importance of health insurance, Ms. Brown has tried to maintain insurance coverage for her daughter. "I have always tried very hard to keep insurance coverage that would protect Shondell, but I have had more and more problems recently. Over the last 3 years I have had different jobs but in each job I was covered by different insurance companies. When it comes to coverage for my daughter under these plans, all these companies told me the same story, the company had exclusions for certain chronic conditions. Sometimes they would not cover treatment for asthma at all, other times they said coverage would not start until I had been a policyholder for at least 2 years. So I found it hard to see what kind of protection the insurance was giving my daughter."

A little over a year ago, Shondell required hospitalization for an acute episode of asthma. Although Ms. Brown's health insurance did not cover the substantial cost of the hospital stay, Ms. Brown's ex-husband helped to pay the bill. Ms. Brown can no longer look to her ex-husband for assistance, and as she stated, "I do not want Shondell's health to depend on whether or not he wants to help out."

Ms. Brown testified that she had been laid off in November and that while she had been given the opportunity to continue with her health insurance policy, she could not afford the cost of the policy without employer contributions. "Of course, I am worried about not having health insurance for myself, but I am more concerned about Shondell with her chronic illness. As I look for work, I am trying to be sure to find a company that has an insurance plan that would cover my family, especially Shondell. Until I get another job and find some other means to get health coverage, I will remain worried about not having protection in case my daughter needs treatment. I am worried that I will hear the same message again, that her condition will not be covered or will require a long waiting period."

Ms. Brown looked into the possibility of obtaining Medicaid coverage, but was told that her income made her ineligible. As Ms. Brown summarized her dilemma, "I know that all of you who are parents understand how painful it would be to see your child gasping or wheezing to get the next breath. When this happens to my daughter, I want to be able to carry her to a doctor right away. But since she is not covered, I do not know what I face if Shondell has another serious attack."

Senator Kennedy noted that his son Patrick is also a chronic asthmatic: "I have made that same trip and you just never know when that child is fighting for breath whether that is going to be the last breath—you just do not know it. And you have difficulty in understanding how anyone can have that much difficulty in breathing and survive."

Ms. Brown described how living in a rural area has created additional problems in seeking treatment for her daughter's chronic illness. She noted that one of her primary concerns was that in the event of an acute asthma attack she has to transport Shondell a long distance in order to find and get adequate care.

Ms. Brown explained that the lack of health insurance makes her reluctant to seek health care for her family except in times of exceptional need. She also acknowledged that this delay in seeking necessary care often makes the original health problem more severe. Congressman Rowland emphasized that, in many instances, earlier access to care would be less expensive and less stressful for the individual.

Joseph Sheppard of Sparta works as a house painter, despite having been born without fingers on his right hand. Mr. Sheppard spoke about the disastrous financial impact of a recent illness, and the extent to which his financial problems were a consequence of his inability, as a self-employed businessman, to obtain affordable health insurance.

During the 15 years he has been self-employed, he has made periodic efforts to obtain an individual health insurance policy. Each time he found the cost prohibitive. Despite having had no major health problems at the time he was seeking coverage, Mr. Sheppard was recently given estimates ranging close to $500 a month for an individual policy. His wife has had several jobs that provided her with health insurance, but these jobs were usually at the minimum wage, and the Sheppards simply could not afford the additional cost of including Mr. Sheppard on her policy.

Despite his concerns about going without health insurance, Mr. Sheppard felt that he had little choice. He was fortunate enough to enjoy 15 years of good health until his recent illness: "This past June of 1989, I became ill. I thought I was coming down with the flu or something similar, or a cold, and I began to treat myself as such. I took some medication that was a little bit too strong for me because I am not used to taking pills, and I became dizzy and I fell down. Although I did not know it at the time, I was suffering from perirectal abscesses. By my falling, I ruptured those abscesses, bringing on severe swelling and soreness."

Mr. Sheppard sought treatment at the Hancock County Primary Health Care Center in Sparta. The physician at the center, Dr. Wendell Smith, examined Mr. Sheppard's condition and urged him to go to the hospital immediately. Mr. Sheppard told the doctor that he did not want to go to the hospital because he did not have health insurance.

After attempting to treat Mr. Sheppard on an outpatient basis for 2 days, Dr. Smith and another local physician, Dr. George Green, were able to convince Mr. Sheppard of the necessity for hospitalization. He was taken to Augusta, 70 miles from Sparta, where he spent 14 days in the hospital, and underwent 3 operations, including a cholostomy. Doctors at the hospital told him that if he had waited another 48 hours before seeking treatment, he might not have survived.

As Mr. Sheppard stated, "Because we did not have insurance, I held off from going to the hospital even though 2 doctors had told me I should go. I am a proudful man and I did not want to make a bill that I could not pay out of my pocket and put me in debt for the rest of my life."

"If I do a painting job for you, Senator, I expect to get paid and likewise so does the hospital if they do work for you. I do not want

to ask for something I could not afford, but in this case, I was forced to it anyway, I had no alternative."

Mr. Sheppard noted that his medical bills totaled $40,000, and that he would be re-entering the hospital the next day in order to have an operation to remove the cholostomy. This procedure will create an additional $10,000 to $15,000 in medical bills. Mr. Sheppard also stated that his wife lost her own health insurance coverage because she had to quit her job in order to take care of him after the operations.

As Mr. Sheppard commented, "Being self-employed is like a feast and famine situation. Your earnings are very much uncertain, you do not know from month to month as to what you are going to make. When you live in a small town like Sparta, it is hard to make a living. It is even harder to afford health care. Living like that can certainly put a person in a poor mental and physical condition. I understand these 2 colleagues (Joan Baity and Debra Brown) that I am with, I know what they are going through."

In closing, Mr. Sheppard expressed his gratitude for the timely services of the Hancock County Primary Health Care Center, noting that he did not believe he would be alive were it not for the help of the Primary Health Care Center. He stated: "I would like to reemphasize just one point on my behalf and for millions of fellow Americans throughout this country of ours, that if it was not for the professional care center, if we should ever lose this center's professional care, my wife and I and others that are in even worse shape than I am, financially or physically, will simply have to just stay home and suffer due to the lack of a doctor's care."

Panel 2: Professionals On The Front Line

Dr. Ted Holloway is a third generation country doctor and the founder of the Daisy Clinic in Waycross, which provides health care services for children. Dr. Holloway is also the director of the Southeast Health Unit of the Georgia Department of Human Resources. The area covered by the unit is about the size of the State of Massachusetts, with a population of 278,000. Seventy-eight percent of the black population in this area and about 45 percent of the white population live below 200 percent of the poverty level.

Dr. Holloway testified that the problems he has seen over the last 4 or 5 years have overwhelmed the health system. He mentioned the numbers of people coming to the health department with chronic diseases that they cannot get care for and that cannot be taken care of in the local hospitals. However, the major problems that he deals with on a day-to-day basis are maternal and child health problems and the problems of infectious diseases.

In the late 1970's, infant mortality in Southeast Georgia was reduced considerably by a coordinated effort led by the health department working with local physicians and hospitals. This improvement is being threatened, however, by the declining numbers of specialists practicing in the area. Dr. Holloway commented, "Since 1980 we have gone from 52 doctors doing deliveries to 26 doctors now doing deliveries, and many of those doctors are older and not sure how much time that they want to continue with medical liability problems and the lack of funding."

Long viewed as an urban problem, Dr. Holloway testified that, "The crack epidemic has just been phenomenal in South Georgia . . . We have seen the crack epidemic go from almost no one using drugs in 1984 to where it seems like [drug use] is everywhere now." Dr. Holloway explained that his area is on the Florida border close to the coast; I-95 and I-75 are 2 major interstate highways that come up through Florida and are drug corridors into his State.

Dr. Holloway estimated that 5 to 10 percent of the pregnant women in the local population are using crack cocaine. "Our low-birth weight babies, less than 500 grams, have tripled from 1986 to 1988. We had the highest infant mortality rate last year. We had a rate of 16.4, which is the highest that we have had since 1978."

Dr. Holloway also described the recent rapid growth he has seen in the incidence of infectious diseases. "Prior to 1984, the most cases of syphilis we had in any 1 year was 60 and we usually ran 40, 50, or 60 cases a year. So far this 11 months, we have had 451 cases of syphilis.

The problem of syphilis relates to another epidemic that has reached rural Georgia, the AIDS epidemic. Dr. Holloway noted that Georgia is among the top 10 States in the country with the number of cases of AIDS per 100,000 population. "Over the next 10 years," he said," we are going to have 10 times as many people with AIDS in the rural areas as we had all during the 1980's."

Dr Holloway explained problems in obtaining care for people with HIV infection: "We see HIV-positive people who cannot get health care. We identify them, we talk with them, we explain to them that they need routine care and yet they cannot get it. So their motivation to either change their behaviors or to get into drug treatment are just not there because it is not available."

In concluding his testimony, Dr. Holloway expressed concern about the future of rural health care. "We are really in a state of crisis in the rural areas with health care that I am becoming really depressed about. I felt that up until about 1984, we were making headway with our alcohol and drug treatment programs, with our mental health centers, our mental retardation programs, and our public health programs. But I feel now, in almost every area, that the gains we have made over the last 20 years are going to be reversed during the next decade . . . I feel that we are in a failing system, and I hope that we do not in this country have to wait until 60 percent of the population is without health care before we make some major changes to provide access to everyone."

On drug abuse, Dr. Holloway stated, "I have no doubt that this is going to spread nationwide and the crack trade is so insidious that it just overwhelms our whole system. We do not have treatment beds, we do not even have counselors within our own system who are familiar with how to treat people who are crack abusers . . . So, I am afraid that it is going to keep going."

Mr. Gary Dolack, administrator of the Hancock Memorial Hospital in Sparta, began his testimony with the comment that although the hearing was being held in rural Georgia, his comments could be readily applied to other rural areas of the country as well.

During the past 2 years, 3 of the 160 rural hospitals that have closed their doors have been in Georgia. Mr. Dolack commented that when a community hospital closes its doors, child health care

suffers, health care to the chronically ill suffers, and access to health care is severely restricted. As he said, "Sometimes the consequences are deadly."

Mr. Dolack explained that the residents of Hancock County knew first hand what a hospital closure means to its community, because in the 1970's Hancock Memorial Hospital was forced to close. "The people wanted the hospital back so badly that they pledged their property taxes to guarantee its operation." In 1985, the hospital reopened but at the cost of a heavy tax burden. Mr. Dolack explained that one-third of the county's expenditures are used to support the hospital. He is hoping that they will be able to cut this burden in half this year. One of the ways to ease this strain would be to strengthen the working relationship between the hospital and the Hancock County Primary Health Care Center.

Mr. Dolack commented that because of a lack of primary care, hospitals in rural areas often see things that one would rarely find in urban locations. He explained, "On 3 occasions at 3 different hospitals, I have seen diabetic patients come in for follow-up care after a lower leg amputation and when the dressing was removed we found that their wounds were filled with maggots. With proper care, this just would not have happened."

Rural hospitals, like their urban counterparts, provide care to many persons who cannot afford to pay and who have no coverage under either a public or a private health insurance plan. At the Hancock Memorial Hospital, Mr. Dolack explained, "Last year we provided more than $300,000 worth of care for which we were not paid. Fortunately, Hancock County stepped in to assist us with its subsidy. Most other hospitals do not have this kind of backing."

Another factor threatening the survival of rural hospitals is the inadequate reimbursement for services rendered to Medicare patients. Mr. Dolack stated that rural hospitals in Georgia expect to receive $26 million less than their costs for treating Medicare patients during 1989. Mr. Dolack concluded, "Rural hospitals throughout this Nation are striving valiantly to fulfill our mission of providing the highest possible quality care to our patients, but we need relief. If we are to continue in operation, a number of actions could be suggested. First, we should find funding for care for those who are currently falling through the cracks, those who have no or little insurance and do not qualify for other coverage and who cannot afford that very necessary care . . . If health care is to be a right, readily accessible to all and not just a privilege of a few, the means to adequately finance that health care, that right, must be found."

"Open Microphone Session"

At the conclusion of the testimony of the witnesses, a number of members of the audience commented on the issues.

Dr. George Green, a local physician and State legislator, reiterated the concerns about Medicare reimbursement rates for rural hospitals.

Ms. Lillian McAfee, mother of a quadriaplegic son, expressed her view that there must be a much wider variety of care options developed for people such as her son.

Alton Spells, Jr., who works for the Rural Health Outreach Program, spoke of the inadequate transportation in rural areas, and noted that his experience in providing maternal and infant care showed that lack of adequate transportation is a major contributor to high infant mortality rates.

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Lilly Warren speaks about the need for expanded home and community-based medical services during "open mike" session.

Lilly Warren, a nurse with Georgia State Community Care Services, stated that she would like to see the Medicaid waiver program for home and community-based services changed to a Medicaid optional service. This action would facilitate the application for Federal assistance. For Community Care Services, this change would make it easier to apply for Federal assistance in providing home health services to low income disabled elderly citizens.

Overview

The site visits and oral testimony demonstrated that the fundamental challenges in providing quality health care in rural areas are the same as those found elsewhere. These challenges include the problems associated with providing health care for the uninsured and the lack of necessary long-term care services.

Often, citizens struggling to care for chronically ill family members at home are struggling to survive themselves. Current policy provides little relief in such cases, even though the care can mean a 24-hour job.

The increasingly common practice of medical underwriting, particularly pre-existing condition exclusions, successfully bars from

coverage those individuals who are most in need of protection against the costs of necessary health care.

For the self-employed, obtaining affordable health insurance is often extremely difficult, particularly if the individual has a pre-existing condition.

The shortage of physicians and other primary health care providers is acute in rural areas, and cutbacks in the National Health Service Corps have contributed to this shortage. Such shortages can lead to reduced access to health care services.

The twin epidemics of drugs and AIDS are rapidly moving into rural areas, and are severely challenging the already strained rural health care system.

APPENDIX A

I. The Basic Health Benefits for All Americans Act (S. 768/H.R. 1845)

All employers must provide a basic package of private health insurance benefits to full-time employees and their dependents. A phased-in public program is established to provide coverage to all other uninsured Americans by the year 2000.

Private Job-Based Insurance for Workers

Employees working 17.5 hours a week or more and their dependents are required to be covered. The employer must pay at least 80 percent of the premium, except for low wage workers, where the employer pays 100 percent. For employees working between 17.5 and 25 hours per week, the employer share of the premium is reduced in proportion to hours worked. Two-thirds of the currently uninsured (23 million people0 will be covered by the job-based plan.

Benefits required to be provided include all medically necessary hospital care, physician care, diagnostic tests, prenatal and well-baby care, and a limited mental health benefit. No exclusions from coverage because of pre-existing conditions are permitted. Deductibles may not exceed $250 per individual and $500 per family; co-payments cannot exceed 20 percent. Each policy must include a catastrophic cap on out-of-pocket expenses for covered services of no more than $3,000.

To promote flexibility in benefit design and minimize interference with existing employment-based coverage, employers may substitute alternative benefit packages, cost-sharing, and premium shares, as long as the package is actuarially equivalent to the statutory plan and the basic required benefits are included.

Public Insurance for Others

The public plan offers coverage to all Americans who cannot obtain it through a job-based plan or an existing public program. A joint Federal-State program is created with Federal matching funds based on the existing Medicaid program. Premiums will be set according to ability to pay. The public plan will also subsidize co-payments and deductibles and the employee share of the premium for low income workers. Benefits are identical to those required under job-based plans.

Because of current budget pressures, the public plan is phased in. Beginning on the effective date of the bill, 4 million children and pregnant women below 185 percent of the poverty level will be covered. Phase II, implemented in 1996, will cover 5.7 million uninsured adults below 185 percent of the poverty line. Phase III, implemented in 1999, will cover the remaining 4.3 million uninsured.

Cost of Plan

The Congressional Budget Office estimates that the Federal cost of the plan will be $3.1 billion in phase I—$1.8 billion for the public plan and $1.3 billion for public costs associated with the private plan. CBO has not estimated the cost of the second and third

phase, but costs should be comparable to phase I, for a total cost of about $9 billion when fully implemented.

The job-based insurance mandated under the plan will cost businesses approximately $18 billion a year including off-sets such as the reduction in current costs to employers of charitable and unreimbursed care. The cost per worker for coverage purchased through an HMO or other managed care plan is $1,100 per year—approximately $4.00 a day.

Small Business Insurance

The plan reforms the insurance market for small business by establishing a system of competing private regional insurers offering the benefits of guaranteed coverage, economies of scale, and community rating. Regional insurers will be required to give small employers the opportunity to enroll in cost-effective managed systems of care such as HMOs and PPOs. These reforms can save small businesses an estimated 25 percent of current premium costs—10 percent in reduced charges for administration and sales costs; and 15 percent through participation in managed care.

Subsidies will be provided to small employers whose costs of compliance exceed 5 percent of gross revenues. If the 5 percent standard is found to be inappropriate for some industries, the Secretary of HHS is required to promulgate an equivalent standard.

The program will be phased in over 5 years for businesses with 5 employees or fewer. New small businesses with fewer than 10 employees may offer an alternative lower cost plan during their first 4 years in operation.

Cost Containment Features

The mandated benefits are constructed to permit employers to use all current cost-containment devices, such as managed care, pre-admission certification, and utilization review.

Employers who currently insure workers will receive reductions of up to 30 percent in health costs as other firms begin to pay their fair share of the Nation's health bill.

Small businesses will receive cost reductions of up to 25 percent as the result of the regional insurance market reforms.

The regional insurer program will encourage the growth of cost-effective managed systems of care with the market power to promote system-wide change.

In order to provide national uniformity, State mandated benefit laws will be pre-empted by the Federal plan.

Congress has recently enacted evaluation research and medical practice standards to eliminate unnecessary care and improve the quality of care. Other inflation-reducing steps that should be adopted include:

Disclosure of cost and quality information by health care providers to assist insurers and consumers in choosing cost-effective care;

Establishment of a national health care cost control review commission to analyze yearly cost increases, set voluntary cost increase targets for the upcoming year, and make annual recom-

mendations to Congress, health care providers, businesses, and consumers for additional actions to reduce inflation.

Demonstration grants to States wishing to develop innovative methods of controlling health care cost inflation.

APPENDIX B

II. "LIFECARE"—THE LONG-TERM CARE INSURANCE ACT OF 1988

Lifecare covers home and community-based care and nursing home care for the elderly and disabled.

Persons eligible for assistance must be (1) totally dependent in at least one "age-appropriate activity of daily living" such as eating, dressing, bathing, toileting, or transferring; (2) dependent upon assistance in at least two such activities; or (3) or cognitively impaired enough to require continual supervision.

The program is divided into Part A and Part B, like Medicare. Part A covers home care and the first 6 months of a nursing home stay, and is financed entirely by public funds. Part B covers longer nursing home stays, and is financed by public funds and private premiums. Enrollment in Part B is voluntary and can occur at age 45 or age 65.

HOME CARE PROGRAM

Benefits include: Homemaker services; home health aid services; heavy chore services; adult day care; respite care; home mobility aids and minor home adaptations; nursing care; physical, occupational, and speech therapy; other services determined to be necessary by a case management agency.

The program is administered through States and local case management agencies, which assess the needs of the patients, develop plans of care with the patient and family, assist in arranging care delivery, and supervise care. The State or case management agency certifies agencies eligible to deliver care, establishes payment rates under Federal guidelines, and pays providers.

NURSING HOME CARE

Eligibility for nursing home care is based on the same disability standards as home care. Nursing home care is provided only if it is better for the patient and consistent with the patient's preference.

Care provided by nursing homes must be certified by the Secretary of Health and Human Services, who is to establish a prospective payment system for such care.

ADDITIONAL PROVISIONS

The bill also includes provisions to expand the supply and improve the quality of long-term care, by offering training for professionals; establishing centers to provide technical assistance to State and local agencies to conduct research; and providing consumer information on services.

FINANCING

CBO estimates the additional Federal cost of the Lifecare plan at $21 billion annually. The program is financed by eliminating the current cap of $50,000 on wages currently subject to the Social Security and Medicare payroll tax. As applied, these taxes are regressive; all workers pay the same percentage rate of tax on the first $50,000 of income and nothing thereafter. Eliminating the cap will raise over $40 billion a year, of which $21 billion will be used to finance Lifecare, and the remainder will be used to reduce the payroll tax.

APPENDIX C

COMPREHENSIVE AIDS RESOURCES EMERGENCY (CARE) ACT OF 1990 (S. 2240)

TITLE I—EMERGENCY ASSISTANCE

It is the purpose of this title to provide emergency relief to those metropolitan statistical areas hardest hit by the AIDS public health disaster. Funds are to be used by eligible individual MSAs to:

(a) support hospitals, clinics, community health centers, and nursing/sub-acute care facilities serving a disproportionate share of low-income individuals and families with HIV disease.

(b) provide case-managed community-based outpatient health and support services for the purpose of reducing hospitalization and expediting discharge.

No funds under this title may be used for renovation or rehabilitation of physical facilities unless the MSA can demonstrate a critical shortage of long-term, sub-acute or congregate care facilities within the service area. Federal funds used for remodeling must be matched (50/50) by the locality/State with allowance for in-kind contribution.

—50 percent of funds appropriated under this program must be distributed to MSAs with greater than 2,000 AIDS cases within 60 days and shall be allotted according to relative number of AIDS cases and per capita incidence within the MSA.

—50 percent of funds shall be awarded by the secretary as supplemental grants to MSAs with greater than 2,000 AIDS cases. Such supplemental grants must be distributed within 5 months after funds become available on the basis of need, local investment, potential for immediate utilization, and development of a comprehensive plan for organization and delivery of HIV care, treatment and support services.

In order to receive funds, political subdivisions within each eligible MSA must establish an intergovernmental agreement and an HIV planning council to govern allocation of resources.

Funds must supplement not supplant existing State, county, or local funds provided for services to individuals with HIV disease. In addition, funds may not be utilized for any purpose not specifically delineated in statute.

Authorizes $300 million for 1991 and 1992 with such sums as may be necessary in 1993, 1994, and 1995.

Title II—Comprehensive Care Programs

It is the purpose of this title to provide for the organization, development and operation of more effective and cost efficient systems for the delivery of essential health care, early intervention and support services to individuals and families with HIV disease in both urban and rural areas. Eligible uses of funds include:

(a) creating and operating local consortia of public and private health and support service entities capable of delivering a comprehensive continuum of care to individuals with HIV disease including children and families in urban and rural areas; a funded consortium must deliver services to the full range of populations with HIV disease within its service area and must include participation of community organizations with a history of service to such individuals;

(b) delivering outpatient, home health and support services to low-income, medically eligible individuals with HIV disease, including outreach to those living in rural areas;

(c) developing and funding mechanisms to assure continuity of health insurance coverage for individuals with HIV disease;

(d) providing therapeutics determined to prevent serious deterioration of health of individuals with HIV disease and establishing a distribution system that facilitates access for such individuals living in rural areas; and

(e) Integrating early intervention services with primary care and support services in existing health care settings, with outreach to individuals with HIV disease living in rural areas.

—Up to 10 percent of the funds appropriated under this title may be reserved by the secretary to directly fund special programs of a national significance for the care of individuals and families with HIV disease and for technical assistance to States.

—The remainder of funds shall be distributed to States based on the number of AIDS cases reported to CDC by the State in the preceding 24 months as a percentage of all U.S. AIDS cases reported in the same period, with consideration given to relative per capita income.

—All States must develop a comprehensive plan for the development and delivery of health and support services to individuals and families with HIV disease in both urban and rural areas..

—All States shall set aside not less than 15 percent of funds for the delivery of health and support services for infants, children, women, and families with HIV disease.

—In States with a significant incidence of AIDS (1 percent or more of the U.S. AIDS cases), not less than 50 percent of funds shall be distributed directly to local entities in areas hardest hit by HIV.

Authorizes $300 million in 1991 and 1992 with such sums as may be necessary in 1993, 1994, and 1995.

TITLE III—HIV HEALTH SERVICES RESEARCH

—Directs the Agency for Health Care Policy and Research to evaluate the impact and cost effectiveness of various models of AIDS care.

Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (S. 2240)

(Attachment A)

AIDS Health Disaster Relief Areas	Adult cases	Child cases
Atlanta, GA	2,561	23
Boston, MA	2,115	42
Chicago, IL	3,094	40
Dallas, TX	2,130	8
Houston, TX	3,715	31
Los Angeles, CA	8,665	74
Miami, FL	2,994	123
New York, NY	24,343	592
Newark, NJ	3,481	99
Philadelphia, PA	2,647	40
San Francisco, CA	7,879	15
San Juan, PR	2,220	85
Washington, DC	3,542	53
Total	69,386	1,225

Eligible Metropolitan Statistical Areas (MSAs) are those with more than 2,000 diagnosed AIDS cases.

As of March 31, 1990, the above cities were eligible for relief according to the Centers for Disease Control.

These 13 cities have 70,611 diagnosed AIDS cases or 55 percent of all cases diagnosed in the United States; this includes 1,225 diagnosed AIDS cases among children or 56 percent of all AIDS cases diagnosed among children in the United States.

State Block Grants—Title II

(Attachment B)

States with significant incidence of AIDS

New York	Illinois	Maryland	Connecticut
California	Puerto Rico	District of Columbia	Michigan
Florida	Pennsylvania	Louisiana	Virginia
Texas	Georgia	Ohio	Missouri
New Jersey	Massachusetts	Washington	Colorado

All States are eligible for Federal monies under Title II.

States with a significant incidence of AIDS = States with more than 1 percent of the total number of AIDS cases reported in the last year are required to spend at least half of grant monies on comprehensive community-based services. Ranked by the number of cases in each, these States are listed above.

On May 17, 1990 the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 passed the Senate by a vote of 95–4. We are extremely encouraged by this bi-partisan show of compassion and look forward to the swift enactment of this critically important legislation.

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